MountainCare
CARING FOR OUR WNC NEIGHBORS

Seating and Wheeled Mobility Clinic Phone 828-820-2828
Return by email <BarbaraC@mtncare.org> or FAX 828-277-4855

HISTORY FORM

Client's Name: _____

DOB: _____

Primary Language: _____
Will you need an interpreter? Yes No

Diagnoses (please list all with Date of Onset): _____

_____

Any other medical conditions (asthma, high blood pressure, arthritis, seizures, latex allergy, **pressure injury** - *currently or history of* wounds, etc.):

_____

_____

Medications: _____

_____

Any previous surgery or any surgery planned for the future? □ Yes □ No

If yes, please list surgery and date _____

_____

Current Weight: _____Height: _____

			Please provide explanation here:
Has your weight been stable	Yes	No	
Do you have feeling in your bottom?	Yes	No	
Do you have bladder control?	Yes	No	
Do you have bowel control?	Yes	No	
Do you have pain?	Yes	No	
Do you have any vision difficulties?	Yes	No	
Do you have any breathing difficulties?	Yes	No	

Are you on oxygen?	Yes	No	
Can you sit unsupported?	Yes	No	
Do you ride in your wheelchair in the vehicle?	Yes	No	
Do you work or go to school?	Yes	No	

Transportation: What type of vehicle(s) do you ride in? _____
If you ride in your wheelchair, how is the chair secured? Tie downs or EZ lock
_____

Ambulation: Are you able to walk? □ Yes □No

With an assistive device? □ Yes □No

With assist of another person? □ Yes □No

What distance can you walk or for how long? _____

Home Environment

Living Situation: □ Alone □ Spouse □ Family □Caregiver □Significant Other
Do you have 24 hour care? □ Yes □ No
Is your caregiver in good health? □ Yes □ No

Accessibility: □ Apartment/Condo □ Nursing Home □ Rest Home □ Assistive Living
□ One Level Home □ Single Wide □ Group Home
□ Two Level Home □ Double Wide

Does the house have a ramp? □ Yes □ No
Does the house have steps to enter? □ Yes □ No How Many? _____
Is there room in the home for a wheelchair? □Yes □ No
Doorway Widths: entrance _____ bedroom_____ bathroom_____ kitchen_____
Will the wheelchair be used in the home for activities such as grooming, dressing, or eating?
□ Yes □ No
Check all the surfaces you must be able to go over in the wheelchair:
Indoor: □ Hardwood/Linoleum/Tile □ Carpet □Door Threshold
Outdoor: □Ramp □ Gravel □ Grass □ Dirt □ Concrete/Asphalt □ Curb □ Inclines

Current Equipment

Do you currently have a wheelchair? □ Yes □ No
If yes, check which one applies: □ Manual □ Power (electric) □ Scooter

Who paid for current wheelchair? _____

Manufacturer/Model of wheelchair and seat cushion/back support: _____

_____

When did you receive this wheelchair/seating? _____

From what Equipment Company? _____

Are you able to push/drive this wheelchair? □ Yes □ No If no, why not? _____

What problems are you having with this chair? _____
_____

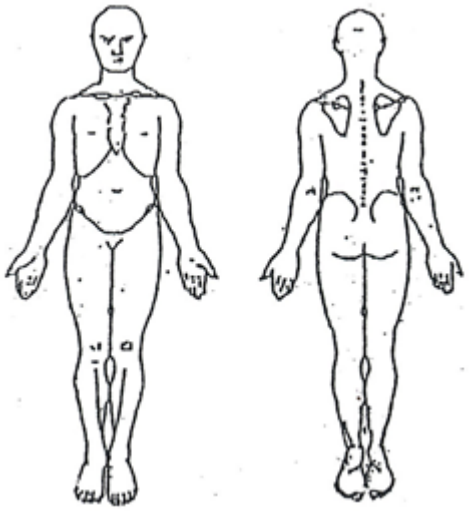
How many hours a day are you in the wheelchair? _____ How many hours at one time _____

Are you comfortable? □ Yes □ No If no, please comment: _____
_____

Transfers: How do you get in and out of the chair/bed/wheelchair? Check all that apply:
□ Independently □ with a transfer board □ with a little help □ with a lot of help
□ one or two people pick me/them up □ using a mechanical patient lift

Are you: □ right handed □ left handed □ mixed

Mark on the diagram where you are having pain:
What is the level of this pain on the 1-10 scale? _____



What are the goals for this evaluation? _____

_____

Is there anything else you would like the therapist to know to help make your visit more pleasant?

_____

Signature of person completing form: _____

Relationship to client: _____

Date: _____