



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: _____ MTC ID: _____

Primary Language: _____ Secondary 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: _____

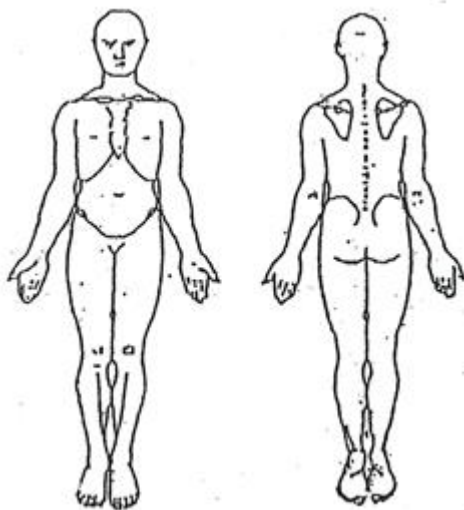
Transfers: How do you get in and out of the chair/bed/wheelchair? Check all that apply:

- 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: _____