

20/A

Sample Form for Comprehensive Positioning Assessment

Name: _____

Date: _____

Section I – III can be completed by the client prior to the clinician's assessment.

I. General Health Survey

Below is a general health survey. Please indicate your current health status for each system.

1. Breathing (Respiratory):

2. Heart and circulatory:

3. Seeing (Vision) :

4. Hearing (Auditory):

5. Talking/ Communication:

6. Feeling (Sensation):

7. Eating (Digestion/Nutrition):

8. Bladder Control :

9. Bowel Control:

10. Skin Condition:

11. Seizures :

12. If you have Pain while sitting or moving around your environment, please indicate where the pain is located and, if possible, how you currently are able to relieve the pain?

13. If you have any restrictions on your mobility activities as a precaution against breaking any bones (fracture) or any other injury, please describe the restriction and reasons, if known?

14. Please list any past or planned surgeries:

Past Surgeries:

Planned Surgeries:

15. Please list any medications you are currently taking:

II. Functional Skills in Present Mobility System

Please complete the following section if you currently use a wheelchair.

Below is a list of activities which you may currently perform while sitting in your chair. If so, please indicate which ones you perform in your chair and a brief description of how you perform the activity (independently or with assistance).

1. Dressing:

2. Bathing:

3. Toileting:

4. Transfers:

a. To & from Bed:

b. To & from

Toilet:

c. To & from

Bathtub:

d. To & from Car:

5. Other critical activities:

III. Environment and Intended Use

Please indicate your expectations of use for a new mobility device, if requested:

Expected Use Place	Full Time	Part Time
Home		
School		
Work		
Leisure/Recreation		
Other		

IV. Mat Assessment

The clinician involved in the assessment is to complete the following postural assessment.

1. Unsupported Sitting Balance

The client is asked to sit (in a short sitting positioning) on a mat table or a bench to assess sitting balance. Ask the client, if able to lift both arms.

A. Hands- Free Sitter:

B. Hands- Dependent Sitter:

C. Prop Sitter:

2. Joint and Muscular Flexibility Assessed Supine

The following describes the "optimal" supine alignment achieved with assistance, as needed.

A. Head/Neck:

- Aligned with trunk
- Laterally flexed to: (R) (L)
- Forwardly flexed
- Hyper extended
- Rotated to: (R) (L)

B. Shoulders:

- Level
- Elevated (R) (L) (Both)
- Subluxed (R) (L) (Both)
- Retracted (R) (L) (Both)
- Protracted (R)(L) (Both)

C. Trunk:

- Straight alignment
- Scoliosis with apex on (R) (L)
- Kyphosis with apex at:
 - (cervical)
 - (upper thoracic)
 - (mid thoracic)

Lumbar Space:

- (normal)
- (flat)
- (hyperlordotic)

D. Rib cage:

- Even
- Rotated forward: (R) (L)

E. Pelvis

Obliquity:

- None (Level)
- (R) side higher than (L)
- (L) side higher than (R)

Tilt:

- None (Neutral)
- Anteriorly tilted
- Posteriorly tilted

Rotation:

- None
- (R) forward
- (L) forward

Lower Externity Ranges for Sitting

- | | | |
|----------------|---------|---------|
| A. Hip Flexion | R _____ | L _____ |
| B. Abduction | R _____ | L _____ |
| C. Adduction | R _____ | L _____ |
| D. Internal F | R _____ | L _____ |
| E. External | R _____ | L _____ |

F. Hip Flexion / Knee Extension

Right: When hip is flexed to _____ knee extends to _____
 Left: When hip is flexed to _____ knee extends to _____

G. Knee Range (with hip flexed):

Right knee from _____ to _____
 Left knee from _____ to _____

H. Ankle

Right:

- Neutral
- Dorsiflexed
- Plantarflexed
- Laterally weight bearing
- Medially weight bearing

Left:

- Neutral
- Dorsiflexed
- Plantarflexed
- Laterally weight bearing
- Medially weight bearing

Notes (especially the influences of tone): _____

V. Evaluation in Support Sitting Position

1. General Statement about Tone

Provide support as needed (perhaps with the assistance of a second person), and observe the person in the short sitting position. Document tonal influences, if any:

Tone \ Location	High	Moderate	Low	Flaccid	Fluctuating	Within Normal Limits
Head/Neck						
Trunk						
Right U.E.						
Left U.E.						
Right L.E.						
Left L.E.						

Influence of Tone on Movement :

Influence of Movement on Tone:

Influence of Tone on Postural Control :

Reflex Activity (ATNR, STNR, Startle, other):

2. Hand Simulation

Describe the posture of the client in a supported short sitting position. Document location, direction and amount of support provided:

A. Head/Neck:

- Aligned with trunk
- Laterally flexed to: (R) (L)
- Forwardly flexed
- Hyper extended
- Rotated to: (R) (L)

B. Shoulders:

- Level
- Elevated (R) (L) (Both)
- Subluxed (R) (L) (Both)
- Retracted (R) (L) (Both)
- Protracted (R)(L) (Both)

C. Trunk:

- Straight alignment
- Scoliosis with apex on (R) (L)
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 - (cervical)
 - (upper thoracic)
 - (mid thoracic)

Lumbar Space:

- (normal)
- (flat)
- (hyperlordotic)

D. Rib cage:

- Even
- Rotated forward: (R) (L)

E. Pelvis

Obliquity:

- None (Level)
- (R) side higher than (L)
- (L) side higher than (R)

Tilt:

- None (Neutral)
- Anteriorly tilted
- Posteriorly tilted

Rotation:

- None
- (R) forward
- (L) forward

Comment on hand placement, direction and amount of support provided at pelvis, trunk and head:

F. Position of Lower Extremities:

Right: Hip Flexed at _____ Knee extends to _____
 Hip is: Abducted _____ Neutral _____ Adducted _____
 Hip is: Intern. Rotated _____ Neutral _____ Exter. Rot _____
 Ankle is: Neutral _____ Dorsiflexed _____ Plantarflexed _____
 Medially weight bearing _____
 Laterally weight bearing _____

Left: Hip Flexed at _____ Knee extends to _____
 Hip is: Abducted _____ Neutral _____ Adducted _____
 Hip is: Intern. Rotated _____ Neutral _____ Exter. Rot _____
 Ankle is: Neutral _____ Dorsiflexed _____ Plantarflexed _____
 Medially weight bearing _____
 Laterally weight bearing _____

Comment on hand placement, direction and amount of support provided at lower extremities:

3. Effect of Gravity on Sitting

A. Backwards Tilt

B. Forwards Tilt

4. Seating System Configuration and Components

A. Seat Width : _____

B. Seat Depth: _____

C. Backrest height : _____

D. Seat to Backrest Angle: _____

E. Seat to Legrest Angle: _____

F. Arm rest height: _____

G. Footrest Length: _____

H. Type of

Backrest: _____

a. Lateral trunk supports needed

b. Lateral pelvic supports needed

I. Type of Seat cushion: _____

J. Type of Head
support: _____

K. Secondary Supports:

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Abstracted from materials by Adrienne Bergen¹ and Jean Ann Zollar²

¹ Seating Assessment Long Form on website: www.rehabcentral.com

² Zollars, JA.: Special Seating; available through Otto Bock 3000 Xenium Lane North, Minneapolis, Minn. 55441 1-800-328-4058.