Center for Assistive Technology & Inclusive Education Studies (CATIES)
at The College of New Jersey

Information Form for Assistive Technology Evaluation: Physical Therapist

_____
(client's name)

will participate in a program review conducted by the Center for Assistive Technology & Inclusive Education Studies (CATIES). Your input is very valuable to the evaluation. Please complete and return this form to your school representative. Thank you for your assistance.

Seating / Positioning (Check all that apply)**:**

- ☐ Sits in regular chair with feet on floor
- ☐ Sits in regular chair with support under feet
- ☐ Sits in adapted chair
- ☐ Sits in wheelchair

Desk Accessibility:

- ☐ Uses regular desk
- ☐ Uses desk with height adjusted
- ☐ Uses adapted table
- ☐ Uses wheelchair for desktop
- ☐ Has difficulty using table or desk

Description of Seating:

- ☐ Seating provides trunk stability
- ☐ Seating allows feet to be on the floor
- ☐ Seating provides 90/90/90 position
- ☐ Has difficulty with head control

Best position for head control is: _____

Summary of student's abilities and concerns related to seating and positioning:

_____

_____

Current fine motor abilities: Student has voluntary, isolated, controlled movements using (Check all that apply) :

- ☐ Left hand
- ☐ Left arm
- ☐ Left leg
- ☐ Left foot
- ☐ Finger(s)
- ☐ Other: _____
- ☐ Right hand
- ☐ Right arm
- ☐ Right leg
- ☐ Right foot
- ☐ Eyebrows
- ☐ Eye(s)
- ☐ Head
- ☐ Mouth
- ☐ Tongue

Mobility (Check all that apply)**:**

- ☐ Walks independently
- ☐ Walks with assistance
- ☐ Walks with appliance
- ☐ Has difficulty walking
- ☐ Has difficulty walking up stairs
- ☐ Has difficulty walking down stairs
- ☐ Needs extra time to reach destination
- ☐ Crawls, rolls, or creeps independently
- ☐ Uses manual wheelchair independently
- ☐ Uses power wheelchair independently
- ☐ Uses wheelchair for long distances only
- ☐ Uses elevator key independently
- ☐ Is pushed in manual wheelchair
- ☐ Learning to use power wheelchair
- ☐ Needs help to transfer in and out of wheelchair
- ☐ Transfers independently

Concerns about mobility (Check all that apply)**:**

☐ Student seems extremely tired after ambulating, requires a long time to recover
☐ Student seems to be having more difficulty than in the past
☐ Student complains about pain or discomfort
☐ Changes in schedule require more time to travel
☐ Changes in location or building are making it more challenging to get around
☐ Transition to new school will require consideration of mobility needs
☐ Other: _____

Summary of student's abilities and concerns related to mobility:

_____
_____

Range of motion: Student has specific limitations to range:

☐ Yes ☐ No

Describe the specific range in which the student has the most motor control:

_____
_____

Reflexes and muscle tone: Student has abnormal reflexes or abnormal muscle tone:

☐ Yes ☐ No

Describe briefly any abnormal reflex patterns or patterns of low or high muscle tone which may interfere with the student's voluntary motor control.

_____
_____

Reliable muscle groups:

Describe muscle groups the student can use consistently and accurately.

_____
_____

Name of person completing form: _____

Signature: _____

Date: _____

School / Program: _____