



Assistive Technology Client Profile Form

Client Name _____ Date _____

Telephone Number _____

Address _____ Age _____

_____ County _____

Disability _____

Are you receiving any other type of assistance, such as fuel, Medicaid, food stamps, etc.?

___ No ___ Yes If yes, what type: _____

Person & affiliation completing form: _____

Telephone: _____ E-mail address: _____

1.

Yes	No
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Do you need assistance caring for yourself in the following areas?

If yes, please check areas of difficulty:

- ___ Putting away groceries
- ___ Preparing meals
- ___ Feeding yourself
- ___ Cleaning house
- ___ Managing trash/recycling
- ___ Doing yard work/gardening
- ___ Doing laundry
- ___ Completing grooming tasks: hair/makeup/ teeth
- ___ Managing dressing tasks: shoe laces/buttons/snaps/zippers
- ___ Taking medications
- ___ Collecting and/or sending mail
- ___ Handling finances/money
- ___ Sensing hot/cold temperatures
- ___ Engaging in home leisure activities
 - ___ Caring for a pet
 - ___ Taking care of houseplants
 - ___ Engaging in crafts
 - ___ Reading

Please list AT you are currently using to assist with above tasks:

Notes _____

2.

Yes	No
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Do you have concerns feeling comfortable and safe where you live now or will live?

If yes, please check areas of difficulty:

- Feeling safe from danger, risk, or injury
- Calling for help – using a telephone
- Receiving professional support
- Having personal supports; such as friends, relatives, and neighbors

Please list AT you are currently using to assist with above tasks:

Notes _____

3.

Yes	No
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Do you have concerns feeling comfortable and safe in the bathroom?

If yes, please check the areas of difficulty:

- Getting in and out of shower/bathtub
- Getting on/off the toilet
- Regulating water temperature
- Turning the tap on/off
- Managing slippery surfaces
- Overflowing the bathtub/sink

Please list AT you are currently using to assist with above tasks:

Notes _____

4.

Yes	No
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Do you have trouble moving from one place to another?

If yes, please check the areas of difficulty:

- Getting up from the floor
- Sitting down/getting up from a chair
- Sitting with stability
- Getting into/out of a car, or into/out of other transportation vehicles
- Driving your own vehicle

Please list AT you are currently using to assist with above tasks:

Notes

5.

Yes	No
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Do you have trouble with mobility / getting around?

If yes, please check areas of difficulty:

Areas of difficulty

- Entering/exiting house
- Traveling on a flat surface
- Balancing
- Climbing stairs
- Descending stairs
- Moving backwards
- Negotiating a path through a house with clutter
- Managing doorway thresholds/opening heavy doors
- Traveling up/down ramps or inclines
- Managing slippery surfaces

AT used

- Manual wheelchair
 - Self-propel using your arms / hands
 - Self-propel using your legs / feet
- Power wheelchair
- Power scooter
- Cane
- Walker

Please list other AT you are currently using for getting around:

Notes _____

6.

Yes	No
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Do you have trouble using your arms / hands / fingers?

If yes, please check areas of difficulty:

- Pushing/pulling/carrying a 5 pound load (a bag of sugar or potatoes)
- Lifting an object over your head
- Stabilizing an object with one hand and acting on it with the other (jar lid)
- Pushing/pulling/sliding objects placed on a counter, table, or shelf
- Rotating your wrists and forearms as if to open a doorknob
- Keeping arm/hand movements steady
- Engaging in fine-motor tasks such as keyboarding, writing, or handicrafts
- Grasping/squeezing and manipulating objects; toothpaste/scissors/knobs/
or handles
- Pinching with power and precision (to tie shoes or put on jewelry)

Please list AT you are currently using to assist with above tasks:

Notes _____

7.

Yes	No
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Do you have trouble communicating with others?

If yes, please check areas of difficulty:

Methods of communication:

- Speaking
- Writing
- Telephoning
- Reading information received
- Other _____

Areas of difficulty:

- Understanding what others are communicating to you
- Getting others to understand you when you communicate with them
- Following or giving directions

Please list AT you are currently using to assist with above tasks:

Notes _____

8.

Yes	No
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Do you have trouble hearing things?

If yes, please check areas of difficulty:

Areas of difficulty:

- Speech/voices on the telephone/TV /music /radio
- Environmental sounds such as a horn beeping/alarm clock
- High frequency sounds such as a telephone/doorbell ringing

AT used:

- Hearing aids
- Other amplification _____

Please list other AT you are currently using for hearing:

Notes _____

9.

Yes	No
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Do you have difficulty smelling / tasting things?

If yes, please check areas of difficulty:

- Smelling/tasting that food has spoiled
- Smelling gas/smoke

Please list AT you are currently using to assist with above tasks:

Notes _____

10.

Yes	No
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Do you have trouble seeing things?

If yes, please check areas of difficulty:

Areas of difficulty:

- Scanning the environment
- Reading mail/newspaper
- Perceiving depth, distance, and edges of things
- Seeing at distances beyond reading distances
- Seeing in dim, reduced, or changing lights

AT used:

- Glasses / contact lenses
- Other visual aids _____

Please list other AT you are currently using:

Notes _____

11.

Yes	No
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Do you have thinking issues that are interfering with your independence?

If yes, please check areas of difficulty:

- Trouble remembering things
- Trouble in planning daily tasks, meals, keeping appointments
- Trouble problem solving (coffee pot not working, see if it is plugged in)

Please list AT you are currently using to assist with above tasks:

Notes _____

What issues would you like to address first? _____

To Be Completed By IPAT:

Why referred? _____

Services requested:

AT Assessment: Area _____

Funding Assistance: _____

Equipment Assistance: _____

Training Needs: _____

Referred to? _____

Date: _____

Summary: _____
