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 | **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 | **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 | **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 | **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 | **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 | **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 | **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 | **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 | **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 | **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 | **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: _____

_____

_____