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:
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:

___________________________________________________________________________
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:
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. **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. **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: ________________________________________________________________
________________________________________________________________________
________________________________________________________________________
