Consumer Evaluation
Functional Skills and Limitations

Date	Consumer			
Home address				
Mailing address if **not** home address				Diagnosis
Phone number / E-mail address				
Age	Male ☐	Female ☐	Height	Weight
Home Owner Yes ☐	No - Owner/Manager Phone			

Upper Extremity Function

	Left	Right
a. Functional movement	None ☐ Average ☐ Low ☐	None ☐ Average ☐ Low ☐
b. Strength	None ☐ Average ☐ Low ☐	None ☐ Average ☐ Low ☐
c. Grip/hand use	None ☐ Average ☐ Low ☐	None ☐ Average ☐ Low ☐

Lower Extremity Function

Mobility:			
a. Utilize steps	Yes ☐	No ☐	Maximum height
b. Oxygen	Yes ☐	No ☐	Portable ☐ Tubing connected to concentrator ☐
c. Assistive devices			Type/Dimensions
Cane	Yes ☐	No ☐	
Walker	Yes ☐	No ☐	
Wheelchair/Scooter Operate independently	Yes ☐ Yes ☐	No ☐ No ☐	Manual ☐ Power ☐ Scooter ☐ Make/Model Serial # Equipment weight: Controller: Left ☐ Right ☐ Arms: Full length ☐ Desk ☐
Transfers:			
a. Bed to wheelchair independently	Yes ☐	No-What assistance is needed and who provides it?	
b. In and out of vehicle and into bathtub/chair independently	Yes ☐	No-What assistance is needed and who provides it?	
c. Fatigue/balance issues	Yes ☐	No ☐	If yes, describe
d. History of falls	Yes ☐	No ☐	If yes, describe injuries, severity, affects