

CLINICAL APPRAISAL AND
MEASUREMENTS FORMS

Issued by :-

Family Support Team

Family Support Services

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Action For Kids Clinical Appraisal Form

Evaluate for: Mobility and Seating Mobility only Seating only

*Client first name _____

*Client last name _____

Family name _____

* Date of birth _____ --dd/mm/yy

Sex Male Female

Height _____ inches

Weight _____

Home phone # _____

Work phone # _____

Clinical Evaluation date / By Whom _____ --dd/mm/yy

Address: _____

Other: (info.) _____

<u>Cerebral Palsy:</u>	Primary	Secondary		Primary	Secondary
Spastic quadriplegia	<input type="radio"/>	<input type="radio"/>	ALS	<input type="radio"/>	<input type="radio"/>
Spastic diplegia	<input type="radio"/>	<input type="radio"/>	Amputee	<input type="radio"/>	<input type="radio"/>
Double hemiplegia	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>
Ataxic	<input type="radio"/>	<input type="radio"/>	CVA-Stroke	<input type="radio"/>	<input type="radio"/>
Athetoid	<input type="radio"/>	<input type="radio"/>	Developmental Delay	<input type="radio"/>	<input type="radio"/>
Spastic athetoid	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>
<u>Spinal Cord Injury:</u>			Dystonia	<input type="radio"/>	<input type="radio"/>
Paraplegic	<input type="radio"/>	<input type="radio"/>	Guillian Barre	<input type="radio"/>	<input type="radio"/>
Tetraplegic	<input type="radio"/>	<input type="radio"/>			
<u>Muscular Dystrophy:</u>			Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>
Duchenne	<input type="radio"/>	<input type="radio"/>	Osteoarthritis	<input type="radio"/>	<input type="radio"/>
Spinal Muscular Atrophy	<input type="radio"/>	<input type="radio"/>	Osteogenesis Imperfecta	<input type="radio"/>	<input type="radio"/>
Wernig Hoffman	<input type="radio"/>	<input type="radio"/>	Pressure Sore	<input type="radio"/>	<input type="radio"/>
Beckers	<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>
Limb Girdle	<input type="radio"/>	<input type="radio"/>	Scoliosis	<input type="radio"/>	<input type="radio"/>
<u>Other</u>			Spina Bifida	<input type="radio"/>	<input type="radio"/>
Describe: _____			Traumatic Brain Injury	<input type="radio"/>	<input type="radio"/>

Client can walk enough to access his / her entire environment? Yes No
Limited by: Respiration Fatigue Pain Incr. asymmetrical posture

Client can push manual wheelchair enough to allow access in a timely manner? Yes No
Limited by: Respiration Fatigue Pain Incr. asymmetrical posture

Cognitive level: Prereadiness Readiness On age level understands safety of self/others

Sensation: Normal Impaired Non-sensate

Level: _____

Skin Integrity: Intact Red area Open area Scar tissue
 History of sores At risk from prolonged sitting

Location: _____

Pressure relief: Independent Assisted Dependent

Method: _____

Bowel: Continent Incontinent Training Continent w/occasional accidents

Bladder: Continent Incontinent Training Catheterized Intermittant cath

Transfers: Independent Dependent Assist Stand-pivot Slide
 Riser / Recliner Assist

Seat height for Transfers _____

Transportation: (Personal Vehicle)

Storage area _____ W x D x H (inches)

Car / Van head clearance: _____ Door (inches)

_____ Inside (inches)

Car / Van door : _____ W x D (inches)

Ramp/lift dimensions: _____ W x D (inches)

Tie down: _____

Environment: _____ Steps from street level into building or main bldg floor to main living area

_____ Bathroom door width

_____ Bedroom door width

Based on supine and corrected sitting assessment describe the next 3 items:

Scoliosis: None Fixed Flexible Corrects w/difficulty

Kyphosis: None Fixed Flexible Corrects w/difficulty

Pelvic obliquity: None Fixed Flexible Corrects w/difficulty

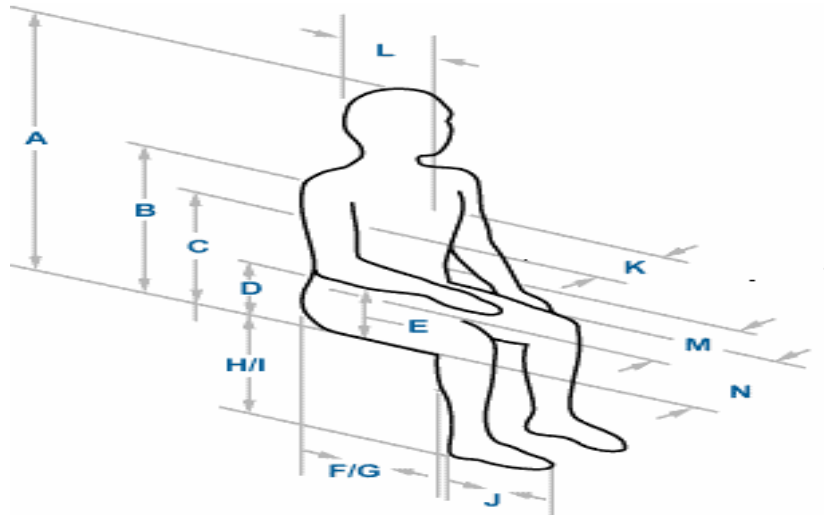
General statement: (about tone, muscle strength, deformity or postural deficits)

Action For Kids Measurements Form

All measurements taken in sitting:

Enter measurements in millimeters or inches with accommodation to all range of motion limitations.

Client name: _____



- | | |
|----------|----------------------------------|
| A: _____ | Sitting surface / crown of head |
| B: _____ | Sitting surface / shoulder |
| C: _____ | Sitting surface / axilla |
| D: _____ | Sitting surface / pelvic crest |
| E: _____ | Sitting surface / hanging elbow |
| F: _____ | Behind hip / popliteal fossa (R) |
| G: _____ | Behind hip / popliteal fossa (L) |
| H: _____ | Popliteal fossa / heel (R) |
| I: _____ | Popliteal fossa / heel (L) |
| J: _____ | Heel / toe |
| K: _____ | Width across trunk |
| L: _____ | Depth of trunk |
| M: _____ | Width across hips |
| N: _____ | Width across knees |