WORKSHEET 1

Mobility & Daily-Routine Needs Assessment

Fill out one copy for each person who will live in the home. Be honest about now and about 10 years from now. If you work with an occupational therapist, bring this with you.

Name: _____

Health or mobility conditions to plan around:

_____

My wheelchair/walker measurements: length _____ width _____ turning space needed _____ seat height _____

QUESTION	NOW	IN 10 YEARS (BEST GUESS)
How I get around (walk, cane, walker, wheelchair, scooter)		
Can I climb stairs? How many, and with a rail?		
Can I climb a ladder safely?		
Balance or dizziness?		
Can I bend to low cabinets / reach high shelves?		
Hand strength (jars, knobs, folding furniture)?		
Vision (low light, contrast, glare)?		
Hearing (alarms, doorbell, phone)?		
Stamina / pain days per week?		
Medical equipment (oxygen, CPAP, lift, dialysis, etc.)		
Help needed with bathing/dressing? From whom?		
Do I drive? Will I?		

Walk through one normal day

MOMENT	WHAT I DO AND WHAT I NEED
Getting out of bed	
Night trip to the bathroom	
Showering / bathing	
Making a meal	
Coming home with groceries	
Pets (feeding, letting out, litter)	
A bad pain or low-energy day	