PIADS Background Form - Wheelchairs #____

Client Name: _____ **ID#** _____ **Today's Date:** _____ **(m/d/y)**

1. I am still using the device
I never used the device.
I no longer use the device that was prescribed for me because: (mark all that apply)
Date you stopped using the device _____(m/d/y)

a) My condition has changed.
b) I've switched devices.
c) I no longer use any kind of mobility device.
d) My wheelchair is broken & not usable.
e) Other (specify): _____

2. When did you obtain your primary mobility device(s)? Month_____Day_____Year _____

3. What kind of wheelchair(s) or mobility device(s) do you currently have? (mark all that apply)

a) Manual Wheelchair with:
- **1)** no seat cushion/ no back support
- **2)** seat cushion & sling back
- **3)** seat cushion & back support
- **4)** manual dynamic recline
- **5)** manual dynamic tilt
- **6)** manual dynamic tilt & recline

b) Electric Scooter

c) Power Wheelchair with:
- **1)** seat cushion & sling back
- **2)** seat cushion & back support
- **3)** power tilt
- **4)** tilt and recline
- **5)** power tilt/recline/zero shear
- **6)** power tilt/recline/zero shear/power legs
- **7)** power wheelchair with midwheel drive

d) Other (specify): _____

4. How do you drive or mobilize your wheelchair(s) or mobility device(s)? (mark all that apply)

a) Direct drive with two hands
b) One handed drive
c) Foot Propulsion
d) Foot Treadle Switch
e) Joystick control Right Left
f) Modified Joystick (e.g. U-stick, T-Stick)
g) Midline Controller (Custom Mount)
h) RIM Controller (Head Joystick)
i) Peach-tree Controller
j) Sip and Puff
k) Tongue Switch
l) Chin Controller
m) Mouth Stick
n) Tiller bar
o) Single switch access
p) Multiple switch access
q) Someone pushes my chair
r) Other (specify): _____

5. Has there been any change in the amount of time that you use your device since getting it? (mark one)
I use it: **a)** as much as I always have. **b)** more **c)** less **d)** other : _____

6. Why do you use your device? (mark all that apply.)

a) It's the only way that I can get around.
b) So that I can go to school or work.
c) It's the only way that I can be independent.
d) It's the only way to approach someone.
e) Because it relieves my pain.
f) Because it increases my sitting tolerance.
g) So that I feel less anxious.
h) So that I feel less self-conscious.
i) Other (please specify):_____

In the next 3 questions please circle a number between 1 and 5.

7. How important do you feel the device is to your life?
Not Important 1 2 3 4 5 **Extremely Important**

8. How would you rate your satisfaction with your present device?
Not Satisfied 1 2 3 4 5 **Extremely Satisfied**

9. How much difficulty did you experience adjusting to your present device?
Extreme Difficulty 1 2 3 4 5 **No Difficulty At All**

For more information, please contact:

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