



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
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Do you need assistance caring for yourself in the following areas?
If yes, please check areas of difficulty:

- ___ Put away groceries
- ___ Prepare meals
- ___ Feed yourself
- ___ Clean house
- ___ Manage trash / recycling
- ___ Yard work / gardening
- ___ Laundry
- ___ Grooming: hair / makeup / teeth
- ___ Dressing: ties / buttons / snaps / zippers
- ___ Take medications
- ___ Collect / send mail
- ___ Handle finances / money
- ___ Sense hot / cold temperatures
- ___ Home leisure
 - ___ Pet care
 - ___ Houseplants
 - ___ Crafts
 - ___ Reading

Please list AT you are currently using to assist with above tasks:

Notes _____

2.

Yes	No
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Do you have concerns feeling comfortable and safe where you live or will live?

If no, please check areas of difficulty:

- Feel safe from danger, risk, or injury
- Call for help – use a telephone
- Professional support
- Personal support, such as friends, relatives, and neighbors

Please list AT you are currently using to assist with above tasks:

Notes _____

3.

Yes	No
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Do you feel comfortable and safe in the bathroom?

If no, 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
- Slippery surfaces
- Bathtub / sink overflowing

Please list AT you are currently using to assist with above tasks:

Notes _____

4.

Yes	No
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Do you have trouble moving from one place to another?
If yes, please check the areas of difficulty:

- Get up from floor
- Sit down / get up from a chair
- Sit with stability
- Get into / out of a car or other transportation
- Drive your own vehicle

Please list AT you are currently using to assist with above tasks:

Notes _____

5.

Yes	No
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Do you have trouble with mobility / getting around?
If yes, please check areas of difficulty:

Areas of difficulty

- Entering / exiting house
- Flat surface
- Balance
- Climb stairs
- Descend stairs
- Move backwards
- Negotiate a path through house and obstacles
- Thresholds (doorways) / opening heavy doors
- Ramps or inclines
- 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:

Notes _____

6.

Yes	No
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Do you have trouble using your arms / hands / fingers?
If yes, please check areas of difficulty:

- ___ Push / pull / carry a 5 pound load (a bag of sugar or potatoes)
- ___ Lift an object over your head
- ___ Stabilize an object with one hand and act on it with the other (jar)
- ___ Push / pull / slide objects placed on a counter, table, or shelf
- ___ Rotate your forearms as if to open a doorknob
- ___ Steady arm / hand movements
- ___ Fine work such as keyboarding, writing, or handicrafts
- ___ Grasp / squeeze and manipulate objects – toothpaste – scissors – doorknobs/handles
- ___ Pinch with power and precision (tie shoes or put on jewelry)

Please list AT you are currently using to assist with above tasks:

Notes _____

7.

Yes	No
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Do you have trouble communicating with others?
If yes, please check areas of difficulty:

Methods of communication:

- ___ Speech
- ___ Writing
- ___ Telephone
- ___ Reading
- ___ Other _____

Areas of difficulty:

- ___ Understand what others are communicating to you
- ___ Get 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:

Notes _____

8.

Yes	No
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Do you have trouble hearing things?

If yes, please check areas of difficulty:

Areas of difficulty:

- ___ Speech / voices on the telephone / TV / music / radio
- ___ Sounds such as a beep / alarm clock
- ___ High frequency sounds such as a telephone or a door chime

AT used:

- ___ Hearing aids
- ___ Other amplification _____

Please list other AT you are currently using:

Notes _____

9.

Yes	No
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Do you have difficulty smelling / tasting things?

If yes, please check areas of difficulty:

- ___ Smell / taste food that has spoiled
- ___ Smell gas / smoke

Please list AT you are currently using to assist with above tasks:

Notes _____

10.

Yes	No
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Do you have trouble seeing things?

If yes, please check areas of difficulty:

Areas of difficulty:

- Scan your environment
- Perceive depth, distance, and edges
- At distances beyond reading distances
- See in dim, reduced, or changing lights

AT used:

- Glasses / contact lenses
- Other visual aids _____

Please list other AT you are currently using:

Notes _____

11.

Yes	No
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Do you have thinking issues that are interfering with your independence?

If yes, please check areas of difficulty:

- Memory
- Planning
- Problem solving

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: _____
