Postural Care Pre-Assessment Questionaire

Please answer the following as best you can. Check the box of **all** options that apply.
Please ask your primary medical provider for information if unknown.

Name: Today's Date: Assessment Date:

Age: Gender: M F Unspecified

What is your medical diagnosis (check all that apply):

- Cerebral Palsy
- Spinal Cord Injury
- Stroke
- Traumatic Brain Injury
- Spina Bifida
- Multiple Sclerosis
- Intellectual Disability
- Cognitive Impairment
- Arthritis
- Osteoporosis
- Incontinence
- Scoliosis
- Dementia

Other/Comments:

Surgical History:

- Hip surgery (dislocation, etc.)
- Spinal surgery (rods, fusion, etc.)
- Tendon release (hamstrings, adductor, etc.)
- Total Joint Replacement (Hip / Knee)
- Unknown

Other/Comments:

Have You Ever Had A Pressure Ulcer (redness or an open wound)?

No Yes If Yes, Shape, Size, & Location:

Do You Currently Have a Pressure Ulcer?

No Yes If Yes, Shape, Size, & Location:

Able to perform independent, consistent & effective weight relief?:

No Yes If Yes, Method of weight shifting:

Comments:

Waterlow Score:

Braden Scale Score:
(if known - likely performed by nursing)

What is Your Preferred Sleep Position?

Do You Experience any of the Following:

Respiratory dysfunction / chest infections?	No	Yes	
Gastrointestinal dysfunction (constipation)?	No	Yes	
# of hospitalizations in last 6months:	0	1-3	> 3
Pain?	No	Yes	

Comments:

Orthoses/Other Equipment:

What goals do you have for this Assessment?

What concerns do you have?

If you are currently using a wheelchair, what do you like and dislike about it?

Is there anything else you would like us to know?

Patient/Client Signature:

Parent/Guardian Signature (if necessary)