Wheelchair Seating Questionnaire ***Please ensure the therapist completes this questionnaire directly with the client. Recommend review of the clinical guide that accompanies this document prior to administration. Content from the clinical guide can be used to help cue clients for potential red flag issues.**	
SKIN	
1.	Do you have any current or previous skin issues over areas of your body that take weight/pressure when sitting up in your wheelchair? If so, please explain.
2.	Have you ever had extended periods of time where you were unable to sit or your sitting had to be restricted due to skin issues from being in your wheelchair? If so, please explain.
Client Responses	
POSTURE	
3.	If I took you out of your wheelchair and asked you to sit up on the side of a bed how much support would you need to keep your body balanced in this position?
4.	Do you ever lose position, or move out of a "straight" position when sitting in your wheelchair? If so, what happens?
Client Responses	

COMFORT	
5.	Do you experience any pain or discomfort when using your wheelchair? If so, please explain.
6.	How do you relieve this pain/discomfort?
Client Responses	
MOBILITY	
7.	If you use a manual chair, do you have any issues or concerns with your ability to push/move the chair wherever you want to go?
8.	If you use a power chair, do you have any issues or concerns with your ability to drive the chair wherever you want to go?
Client Responses	
FUNCTION	
9.	Are there any functional tasks that you need to be able to do from your wheelchair that are causing issues for you? Please consider the following areas of function: self-care, home management, transportation, community management
10.	Are you continent of bladder and bowel? If not (for either or both) what do you do to manage your bladder and/or bowel incontinence?
Client Responses	