



This information is collected only to ensure the safety of the participant and that of association staff.

**Name (Last name, First name):** \_\_\_\_\_

**STM # :** \_\_\_\_\_

**Spoken language (s) :** French  English  Other \_\_\_\_\_

**Weight (pounds):** \_\_\_\_\_

**Height (cm)** \_\_\_\_\_

## Mobility :

Walks without aid

Walks with technical aid  Specify : \_\_\_\_\_

Wheelchair : manual  power wheeled chair  scooter

## Details on limitations :

Primary limitation : \_\_\_\_\_

Nature of the incapacity: \_\_\_\_\_

Communication : \_\_\_\_\_

Vision : \_\_\_\_\_

Hearing : \_\_\_\_\_

Sensation : \_\_\_\_\_

Associated conditions (Hypertension, allergies, etc.) :

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**Recommended transfer :**

- With help from one
- With help from two people
- Mechanical lift & sling

**Upper limb functions**

- Uses one or both hands without difficulty
- Paralysis or weakness of one arm  left  right
- Paralysis or weakness of both arms

**Stability**

- Adequate head control
- Requires head support
- Adequate trunk control
- Requires trunk control

**Other Specific need :**

\_\_\_\_\_

**Therapist name:** \_\_\_\_\_

**Specialty (eg :ergo, nurse):** \_\_\_\_\_

**Date :** \_\_\_\_\_