



ISWP Mobility and Wheelchair Survey

ISWP recommends service providers collect the following data points during wheelchair service and provision with clients. The data can be gathered for a client who is being evaluated to receive a wheelchair for the first time or for a replacement wheelchair. Interviewers who are translating the questions for clients may use their discretion with wording and phrasing and avoid any sensitive questions. The minimum information ISWP would like to have is shown in bold. There also is a version of the survey available, the “short version”, with fewer questions.

Client and Wheelchair Clinic Information (This section to be completed by service provider, with client input)

1. Client’s Name: _____ **2. Client’s ID Number:** _____

3. Client Home Address – House number and street: _____

Town/District/Postal Code: _____ **Country:** _____

4. Wheelchair Clinic Name: _____

5. Wheelchair Clinic Address – Number and street: _____

Town/District/Postal Code: _____ **Country:** _____

6. Name of person at Wheelchair Clinic: _____

7. Date completed: _____ 8. Completed by client Completed by caregiver/parent (*Check one*)

[Purpose of Visit](#)

9. Why are you here today? (Check one.)

- I am here to get a wheelchair.
- My wheelchair is broken.
- I have a wheelchair that does not meet my needs.
- I am here for routine follow-up for my wheelchair.
- I am here for a health check.
- I am here to participate in a research study about wheelchairs.
- I am here to participate in a research study about another topic.
- I am here to participate in a training.
- Not sure

10. If you were referred to this service by a person or organization, please provide the name:

[Demographics](#)

11. Age/approximate age: _____ Not sure

12. What is your gender? Male Female No answer

13. What is the highest level of education you completed? *(Check one)*

- Finished some Primary School
- Primary School Graduate
- Finished some Secondary School
- Secondary School Graduate
- Finished some College or University
- College or University Degree
- Advanced Degree (Masters, PhD)
- Vocational training
- None

14. What is your current employment status? *(Check one)*

- Employed Full Time (at least 40 hours a week)
- Employed Part Time (less than 30 hours a week)
- Unemployed (but not a homemaker)
- Homemaker/full-time parent
- Student
- Child not attending school

15. Check all the people who currently live with you:

- Parent or parents
- Sister or sisters
- Brother or brothers
- Husband, wife, spouse or partner
- Child or children
- Other family members, such as grandparent, aunt, uncle, cousin
- Friends or other people who are not related
- Live alone

[Reasons for Assistance](#)

16. About how long have you needed something to help you walk or move, such as a wheelchair or walker? *(Write in number. Check box to indicate whether number is months or years.)*

_____ Months Years Not sure

17. Why do you need help to walk or move? (Check one that most applies to you.)

- Amputation
- Brain Injury
- Cerebral Palsy
- Muscular Dystrophy
- Osteogenesis imperfecta
- Polio
- Spina Bifida
- Spinal Cord Injury
- Spinal Tuberculosis
- Stroke
- Injury
- Have a hard time walking
- Not sure

18. What year did you receive this diagnosis? (Write in number) Year _____ Not sure

19. Put a check in the box below the statement that best describes how much difficulty you have walking a long distance (100 meters):

<i>No Difficulty</i>	<i>Some Difficulty</i>	<i>A lot of Difficulty</i>	<i>Severe Difficulty/ Cannot walk 100 meters</i>

20. Do you have someone helping you when you are indoors? (Check one) Yes No Not sure

21. Do you have someone helping you when you go outside? (Check one) Yes No I do not go outside Not sure

Items Used to Help Walk or Move

22. The table below includes a list of common things to help you walk or move, like wheelchairs, braces and walkers. Please think about all of the things you own to help you walk or move and how you use them. Please provide answers for each item you use regularly in the table below. If you do not own a specific item listed, or you own it but do not use it on a regular basis, please leave the row blank.

<i>Items to help you walk or move</i>	<i>Put a check in this column if you currently own this item</i>	<i>Put a check in this column if you use this item indoors</i>	<i>Put a check in this column if you use this item outside</i>	<i>Put a check in this column if you have used this item for more than one year</i>	<i>In a typical week, how many <u>days</u> do you use this item? (Put a number between 1 and 7.)</i>	<i>In a typical week, how many hours each day do you use this item? (Put a number between 1 and 24.)</i>
Manual wheelchair						
Electrically powered wheelchair						
Board with wheels						
Hand-powered cycle						
Walking Stick or Cane						
Crutch or Crutches						
Walker or Walking Frame						
Brace or Braces						
Artificial limb or limbs						
Other _____						

None used currently

<p>If you currently have a wheelchair, please continue with the survey.</p>	<p>If you do <u>not</u> currently have a wheelchair, you are finished with the survey. Thank you for your input.</p>
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[Questions for Current Wheelchair Users](#)

For the next few questions, think about your current wheelchair. If you are getting a new wheelchair at your visit today, think about the wheelchair you have used up until this visit.

23. Put a check in the box below the statement that best describes how much difficulty you have pushing your current wheelchair. (Check one)

<i>No Difficulty</i>	<i>Some Difficulty</i>	<i>A Lot of Difficulty</i>	<i>Severe Difficulty</i>
<i>I can push my own wheelchair without any problems</i>	_____		<i>I cannot push my own wheelchair.</i>

24. How do you typically push your wheelchair? (Check the one method you use most often.)

- Both arms
- One arm
- Both legs
- One leg
- Have someone else push
- Not sure

25. If you do not push your wheelchair with your arms or legs, please check the top reason you do not push your chair:

- The wheelchair does not fit well enough for me to push myself.
- I do not know how to push the wheelchair myself.
- My upper body is not strong enough to push using my arms.
- I would rather have someone else push me.
- My lower body is not strong enough to push the wheelchair myself.
- Not sure

26. Please read each statement and check Yes or No.

	Yes	No
I use my wheelchair at home.		
I use my wheelchair at school.		
I use my wheelchair at work.		
I use my wheelchair at other places outside home.		
I use my wheelchair to get from place to place.		
I use my wheelchair as a seat in a vehicle.		

27. About how far do you travel each day in your wheelchair? (Check one) Up to 1 km 1-5km More than 5km Not sure

28. Do you often use public/private transportation? (Check one) Yes No Not sure

29. If you do use public or private transportation, what kind do you use? (Check all that apply.) Car Taxi Bus Other (describe below)

Other (Describe): _____

30. Have you ever fallen over in your wheelchair or fallen out of your wheelchair? Yes No Not sure

31. How did you get your wheelchair? (Check one.)

- I paid for the wheelchair myself, or my family paid for it
- From a church
- From a charitable organization
- At a hospital or clinic
- At school
- From the government
- Through a research study
- From a pharmacy or medical supply store
- Not sure

32. Please check in box the next to how much you agree with each statement about your wheelchair.

<i>My Current Wheelchair...</i>	<i>Yes, Mostly Agree</i>	<i>Yes, Somewhat Agree</i>	<i>No, Not at All Agree</i>
Meets my needs.			
Is in good working order.			
Is safe to use.			
Fits my body well.			
Supports me to sit up.			
Is easy to push on my own.			
Works well in places I need to go.			
Has a cushion that is in good working order.			
Has a cushion that is safe to use.			
Has a cushion that helps to keep me from getting sores.			
Has a cushion that helps to keep me from developing other problems.			

33. Put a check in the box below the statement that best describes, in general, how satisfied you are with your current wheelchair.

<i>Not satisfied at all</i>	<i>Not very satisfied</i>	<i>Somewhat satisfied</i>	<i>Quite satisfied</i>	<i>Very satisfied</i>

34. Please put a check in the box next to the type of training you received about how to use your wheelchair. Write in about how many hours of training you received. Training might cover things like getting around in a wheelchair or taking care of pressure sores.

<i>Training</i>	<i>Check all training you have received</i>	<i>About how many hours of training</i>
How to get in and out of a wheelchair		
How to push the wheelchair		
Preventing pressure sores, such as performing pressure relief (leaning or lifting often)		
How to maintain the wheelchair		
How to repair the wheelchair		

None

Please have the person working with you complete the following questions:

35. For each item you use to help you walk or move, please tell us the manufacturer name, model/make and serial number, if you know it. (If you use something not listed here, describe below. If you do not use any items currently, please check the box at the bottom of the list. If you do not know or do not want to answer, please check either box at the bottom of the list.)

<i>Items to help you walk or move</i>	<i>Manufacturer Name</i>	<i>Model/Make</i>	<i>Serial Number</i>
Manual wheelchair			
Electrically powered wheelchair			
Board with wheels			
Hand-powered cycle			
Walking Stick or Cane			
Crutch or Crutches			
Walker or Walking frame			
Brace or Braces			
Artificial Limb or Limbs			
Other _____			

None used currently

Not sure

Other (Describe) _____

36. Please check the box next to each item your wheelchair has -- a cushion or device to help support your back. Write in the name of the manufacturer and make or model name or number, if you know it. If you use something else that makes you more comfortable, describe in the area below.

		<i>Manufacturer Name</i>	<i>Make or Model Name or Number</i>
<input type="checkbox"/>	Cushion with foam inside		
<input type="checkbox"/>	Cushion with gel inside		
<input type="checkbox"/>	Cushion with air inside		
<input type="checkbox"/>	Cushion, do not know what is inside		
<input type="checkbox"/>	Postural support device or devices		

Other, please describe: _____

I do not use anything

Not sure

You are finished with the survey.

Thank you for your input.