SPAULDING
OUTPATIENT CENTER
LEXINGTON

EQUIPMENT QUESTIONNAIRE

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:** **Age:**
Referring doctor:	**Height**:	**Weight**:

Medical History		
Diagnosis:		
Equipment		
Requesting Trial of: **Due to concerns of:**		
Currently Own	Vendor	Date Received
Social/Architecture		
Lives with:		
Type of home/apt:	Type of car:	
Stairs (inside/outside):	Ramp:	
School		
IEP services:	Type of transportation:	
Limitations		
Hearing:		
Vision:		
Strength deficits:		
Tone:		
Limited Range of motion:		
Scoliosis:		
Leg Length discrepancy:		
Skin integrity:		
Endurance:		
Ability to follow directions:		
Communication style:		
Safety Concerns:		