

Initial Worksheet for the Matching Person & Technology Process

Name: _____ Today's Date: _____ Form completed by: _____

In which of the following Domains does the individual experience a limitation or have a particular strength? Check all that apply. For each area, indicate goals as well as potentially desirable interventions (for example, environmental accommodations, personal assistance) for this person.

Domain	Limitations	Strengths	Goals	Interventions
Speech/Communication				
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

Examples: Technologies - Electronic communication device, manual board. **Accommodations** - Communication skill training for key others.

Mobility

1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

Examples: Technologies - Wheelchair, walker, adapted driving controls. **Accommodations** - Ramps, appropriate surfaces.

Dexterity/Hand Use

1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

Examples: Technologies - Adapted computer keyboard and mouse, grooming aids. **Accommodations** - Automatic door openers, touch screen bank terminals.

Seeing

1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

Examples: Technologies - Magnification devices, reading machines. **Accommodations** - Appropriate lighting, tactile labeling/signage

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Domain	Limitations	Strengths	Goals	Interventions
Hearing				
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

Examples: Technologies - Phone amplifier, personal FM system, signaling devices. **Accommodations** - Noise reduction, captioned programs.

Reading and Writing				
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

Examples: Technologies - Books on tape, computer with speech output. **Accommodations** - trained readers/notetakers, testing accommodations

Household Activities				
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

Examples: Technologies - Adapted household appliances, EADLs. **Accommodations** - Appropriate design/layout of counters.

Health Maintenance				
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

Examples: Technologies - Self-monitoring devices, self-administered medication. **Accommodations** - Safety back-ups in place, caretaker training

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Domain	Limitations	Strengths	Goals	Interventions
Recreation and Leisure				
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.
Examples: Technologies - Adapted skis, beeper baseball. Accommodations - Available recreational opportunities and staffing.				
Self-care				
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.
Examples: Technologies - Adapted devices for eating, bathing, grooming, dressing. Accommodations - Home access is optimal, autonomy is supported.				
Employment				
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.
Examples: Technologies - Adapted tools, computer workstation. Accommodations - Support of colleagues and employer.				
Thinking, Understanding, and Remembering				
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.
Examples: Technologies - Memory and spelling aids, educational software. Accommodations - Setting free of noise/ distraction.				

1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

History of Support Use: Technologies, Special Purpose Devices, and Personal Assistance

Name: _____ Today's Date: _____ Form completed by: _____

In which areas does the person (a) use, (b) have past use, and (c) need a technology or other support? Write the name of the support in each relevant domain, and then record the information requested under the one most appropriate column.

Name of Support Used	SUPPORT CURRENTLY USED			SUPPORT USED IN THE PAST (not listed under currently used)				SUPPORT NEEDED		
	Months Used	% of Day Used	Satisfaction with support (1=very dissatisfied, 3=neutral, 5=very satisfied)	Months Used	% of Day Used	Satisfaction with support (1=very dissatisfied, 3=neutral, 5=very satisfied)	Reason for No Longer Using	Need and Want but Does Not Have	Need but Does Not Want	Reason
Speech/communication										
1.										
2.										
3.										
Mobility										
1.										
2.										
3.										
Dexterity, hand use										
1.										
2.										
3.										
Seeing										
1.										
2.										
3.										

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Hearing										
1.										
2.										
3.										
Reading/Writing										
1.										
2.										
3.										
Household Activities										
1.										
2.										
3.										
Health Maintenance										
1.										
2.										
3.										

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Recreation and Leisure										
1.										
2.										
3.										
Self-care										
1.										
2.										
3.										
Employment										
1.										
2.										
3.										
Thinking, Understanding, and Remembering										
1.										
2.										
3.										

Name _____
Device _____

Form completed by _____
Today's Date _____

1. TECHNOLOGIES YOU FREQUENTLY USE:

List the technologies that you use most frequently (for example, personal computer, VCR, bank ATM, CD player, etc.)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Answer all the questions below by checking the option that most accurately applies to you.
If you are uncertain about a response, check the neutral category.

2. OVERALL EXPERIENCES WITH CURRENT TECHNOLOGIES USED

	<i>Generally Feel</i>	<i>Neutral</i>	<i>Generally Feel</i>	
They are satisfying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	They are frustrating
They help my creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	They interfere with my creativity
They are encouraging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	They are discouraging
They bring me together with people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	They separate me from people
They raise my opinion of myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	They lower my opinion of myself

3. PERSPECTIVES ON TECHNOLOGIES

	<i>Feel Positive About</i>	<i>Neutral</i>	<i>Feel Negative About</i>	
My childhood technology experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My childhood technology experiences
My technology experiences in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My technology experiences in school
My technology experiences at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My technology experiences at home
My most recent technology experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My most recent technology experiences

	<i>Generally Feel</i>	<i>Neutral</i>	<i>Generally Feel</i>	
I am comfortable with technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am intimidated by technology
I approach technology in a THINKING way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I approach technology in a FEELING way
I feel good around technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I feel anxious around technology
Other people encourage my technology use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other people discourage my technology use

4. YOUR TYPICAL ACTIVITIES:

	<i>Generally Feel</i>	<i>Neutral</i>	<i>Generally Feel</i>	
I prefer to be active (sports, walking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I prefer passive activities (reading, TV)
I prefer group activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I prefer solitary activities
My activities are satisfying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My activities are frustrating
I regularly seek fresh, new activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My activities have not changed in a long time

5. SOME OF YOUR PERSONAL/SOCAL CHARCTERISTICS

	<i>Generally Feel</i>	<i>Neutral</i>	<i>Generally Feel</i>	
Composed/calm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxious
Happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depressed
Tolerant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angry or frustrated
Positive in outlook	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Negative in outlook
Expressive/ outgoing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quiet/withdrawn
Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impatient
Motivated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unmotivated
Persevering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily discouraged

	<i>Generally Feel</i>	<i>Neutral</i>	<i>Generally Feel</i>	
I am a THINKING person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am a FEELING person
I frequently interact with family/ spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I seldom interact with family/ spouse
I frequently interact with non- family/friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I seldom interact with non- family/friends
I have a good sense of well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have a poor sense of well-being
I am physically independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am physically dependent
I am emotionally independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I am emotionally dependent

----- **SURVEY OF TECHNOLOGY USE** -----

SCORING:

Determine which responses are *positive*, *neutral*, or *negative*. For each major category, total (sum) the number of items checked in the corresponding heading. Then, total the scores in each column.

MAJOR CATEGORY	<u>POSITIVE</u>	<u>NEUTRAL</u>	<u>NEGATIVE</u>
2. Experiences with Current Technologies:			
3. Perspective on Technologies:			
4. Typical Activities:			
5. Personal/ Social Characteristics:			
TOTAL			

Name _____
Device _____

Form completed by _____
Today's Date _____

1. TECHNOLOGIES USED:

List the technologies used most frequently by this user (for example, personal computer, VCR, bank ATM, CD player, etc.)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Answer all the questions below by checking the option that most accurately applies.
If you are uncertain about a response, check the neutral category.

2. EXPERIENCES WITH CURRENT TECHNOLOGIES USED

	<i>Generally Feels</i>	<i>Neutral</i>	<i>Generally Feels</i>	
Satisfying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frustrating
Helps creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interferes with creativity
Encouraging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discouraging
Brings together with people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Separates from people
Raises opinion of self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lowers opinion of self

3. PERSPECTIVES ON TECHNOLOGIES

	<i>Feels Positive About</i>	<i>Neutral</i>	<i>Feels Negative About</i>	
Childhood technology experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Childhood technology experiences
Technology experiences in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Technology experiences in school
Technology experiences at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Technology experiences at home
Most recent technology experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Most recent technology experiences

	<i>Generally Feels</i>	<i>Neutral</i>	<i>Generally Feels</i>	
Comfortable with technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intimidated by technology
Approaches use in a THINKING way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Approaches use in a FEELING way
Feels good around technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feels anxious around technology
Others encourage technology use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Others discourage technology use

4. TYPICAL ACTIVITIES:

	<i>Often</i>	<i>Neutral</i>	<i>Often</i>	
Prefers to be active (sports, walking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prefers passive activities (reading, TV)
Prefers group activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prefers solitary activities
Activities are satisfying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Activities are frustrating
Regularly seek fresh, new activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has not changed activities in a long time

5. PERSONAL/SOCAL CHARCTERISTICS

	<i>Often Feels</i>	<i>Neutral</i>	<i>Often Feels</i>	
Composed/calm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxious
Happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depressed
Tolerant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angry or frustrated
Positive in outlook	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Negative in outlook
Expressive/ outgoing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quiet/withdrawn
Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impatient
Motivated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unmotivated
Persevering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily discouraged
	<i>Positive</i>	<i>Neutral</i>	<i>Negative</i>	
Is a THINKING person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is a FEELING person
Frequently interacts with family/ spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seldom interacts with family/ spouse
Frequently interacts with non-family/friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seldom interacts with non-family/friends
Good sense of well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor sense of well-being
Physically independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physically dependent
Emotionally independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotionally dependent

----- **SURVEY OF TECHNOLOGY USE -P** -----

SCORING:

Determine which responses are *positive*, *neutral*, or *negative*. For each major category, total (sum) the number of items checked in the corresponding heading. Then, total the scores in each column.

MAJOR CATEGORY	<u>POSITIVE</u>	<u>NEUTRAL</u>	<u>NEGATIVE</u>
2. Experiences with Current Technologies:			
3. Perspective on Technologies:			
4. Typical Activities:			
5. Personal/ Social Characteristics:			
TOTAL			

Name _____ Age _____
 Primary Goals (6 months) _____ Today's Date _____
 Primary Goals (1 year+) _____ Form Completed By _____

A. How would you rate your abilities today in the following 9 areas when using your current AT or other support?

- For items 1-9, mark the best response (1 for *poor* through 5 for *excellent*).
- Under **Name of Support** write the name of the support you use where relevant (example: 'eyeglasses' for # 1, *seeing*).
- Write a plus [+] in the spaces where you expect to need more support over the next year (example: 'eyeglasses' gets [+] if you'll expect to need stronger lenses during the next year). Write a [-] in the spaces where you expect to need less support, and a [0] where you expect your support should stay the same over the next year.

	Poor	Average	Excellent	Name of Support	Need more [+], less [-], same [0]		
1. Seeing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
2. Hearing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
3. Speech	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
4. Understanding, remembering	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
5. Physical strength/stamina	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
6. Lower body use (hips, legs, feet)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
7. Grasping and use of fingers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
8. Upper body use (arms, shoulders, trunk)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
9. Mobility (getting from place to place)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____

B. How satisfied are you currently in the following areas?

- For items 10 – 21, circle the best response (1 for *Not Satisfied* through 5 for *Very Satisfied*).
- Which 3 items are most important to you? Under **3 Most Important**, write #1, #2 or #3 for the three areas that concern you most (#1=most important). Leave the other lines blank.
- For your 3 *Most Important* items, write the primary obstacles and barriers you face in the space beside that item.

	Not Satisfied	Satisfied	Very Satisfied	3 Most Important			
10. Personal care and household activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
11. Physical comfort & well-being	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
12. Overall health	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
13. Freedom to go wherever desired	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
14. Participation in desired activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
15. Educational attainment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
16. Employment status/potential	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
17. Family relationships	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
18. Close, intimate relationships	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
19. Autonomy and self-determination (choosing)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
20. Fitting in, belonging, feeling connected	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
21. Emotional well-being	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____

C. PLEASE MARK ALL THE STATEMENTS BELOW THAT DESCRIBE YOU. Mark only those that *frequently or often* apply to you and ignore those that *very rarely or never* apply to you..

- | | | |
|---|--|---|
| <input type="checkbox"/> 22. I have the support I want from family | <input type="checkbox"/> 33. I am usually calm and patient | <input type="checkbox"/> 44. I find technology interesting |
| <input type="checkbox"/> 23. I have the support I want from friends | <input type="checkbox"/> 34. My life has purpose, meaning | <input type="checkbox"/> 45. I am cooperative |
| <input type="checkbox"/> 24. I feel encouraged by therapists, caregivers | <input type="checkbox"/> 35. I am self-disciplined | <input type="checkbox"/> 46. I prefer a quiet lifestyle |
| <input type="checkbox"/> 25. I feel the general public accepts me | <input type="checkbox"/> 36. I am often angry | <input type="checkbox"/> 47. I often feel isolated & alone |
| <input type="checkbox"/> 26. I aspire to go to school or work | <input type="checkbox"/> 37. I am often depressed | <input type="checkbox"/> 48. I accomplish what I set out to do |
| <input type="checkbox"/> 27. I have many things I want to accomplish | <input type="checkbox"/> 38. I prefer to be left alone | <input type="checkbox"/> 49. I am not sure who I am now |
| <input type="checkbox"/> 28. I do what my therapists say without question | <input type="checkbox"/> 39. I am often discouraged | <input type="checkbox"/> 50. I want more independence |
| <input type="checkbox"/> 29. I view my therapist(s) as friends, too | <input type="checkbox"/> 40. I am quite resourceful | <input type="checkbox"/> 51. I have a good self image |
| <input type="checkbox"/> 30. I am often frustrated or overwhelmed | <input type="checkbox"/> 41. I like having a challenge | <input type="checkbox"/> 52. I often feel insecure |
| <input type="checkbox"/> 31. I am curious & excited about new things | <input type="checkbox"/> 42. I am responsible & reliable | <input type="checkbox"/> 53. I feel as if I have little privacy |
| <input type="checkbox"/> 32. I am determined to meet my goals | <input type="checkbox"/> 43. I am generally satisfied with my life | <input type="checkbox"/> 54. My therapist(s) know better than I what I need |

D. COMMENTS:

For Determining How Well Devices Used Match with Desired Outcomes

Name _____ Form completed by _____
 Primary Goals (6 months) _____ Today's Date _____
 Primary Goals (1 year+) _____

DIRECTIONS: Write the name of each device you are rating in the boxes below under **Device**. An example has been provided. Write how many hours per day you currently use each device. For each device, enter a [x] for the 3 items (A-L) that are most important to you. Then rate each device on the 12 items (A-L) according to the following scale and write your ratings in the appropriate boxes:

- | | |
|--|--|
| 5 = All the time (100% of the time) | 2 = Sometimes (around 25% of the time) |
| 4 = Often (around 75% of the time) | 1 = Not at all (0% of the time) |
| 3 = Half the time, neutral (about 50% of the time) | 0 = Not applicable |

	Question	Example Quad Cane	Device 1: _____ (device name)	Device 2: _____ (device name)	Device 3: _____ (device name)
	How many hours a day I currently use this device...	12 hours			
A	This device is helping me to achieve my goals (including the primary AT goals written above).	5			
B	This device is benefiting me and improving my quality of life.	3			
C	I'm confident I'm getting the most out of this device and its various features.	x 4			
D	I feel more secure (safe, sure of myself) when using this device.	x 5			
E	This device fits well with my accustomed routine.	4			
F	I have the capabilities and stamina to use this device without discomfort, stress and fatigue.	x 3			
G	I have the supports, assistance and accommodations to successfully use this device.	4			
H	This device physically fits in all desired environments (car, living room, etc.).	3			
I	I feel comfortable (and <i>not</i> self-conscious) using this device around family.	4			
J	I feel comfortable (and <i>not</i> self-conscious) using this device around friends.	4			
K	I feel comfortable (and <i>not</i> self-conscious) using this device at school or work.	4			
L	I feel comfortable (and <i>not</i> self-conscious) using this device around the community.)	4			
	Total <small>(add A-L)</small>	47			

Review the scores above. In general, taking into account any items that were scored 0 for *Not applicable*, the higher the **total score** (the maximum number of points=60), the more satisfied you are and the more usable the device. However, when multiple devices are being compared and total scores are close, more weight should be given to the 3 items checked as being *most important*.

COMMENTS AND NOTES:

Name _____ Age _____
 Primary Goals (6 months) _____ Today's Date _____
 Primary Goals (1 year+) _____ Form completed by _____

A. How would you rate your abilities today in the following 9 areas when using your current AT or other support?

- For items 1-9, mark the best response (1 for *poor* through 5 for *excellent*).
- Under **Name of Support** write the name of the support you use where relevant (example: 'eyeglasses' for # 1, *seeing*).
- Write a plus [+] in the spaces where you expect to need more support over the next year (example: 'eyeglasses' gets [+] if you'll expect to need stronger lenses during the next year). Write a [-] in the spaces where you expect to need less support, and a [0] where you expect your support should stay the same over the next year.

	Poor	Average			Excellent	Name of Support	Need more [+], less [-], same [0]
1. Seeing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
2. Hearing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
3. Speech	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
4. Understanding, remembering	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
5. Physical strength/stamina	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
6. Lower body use (hips, legs, feet)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
7. Grasping and use of fingers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
8. Upper body use (arms, shoulders, trunk)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
9. Mobility (getting from place to place)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____

B. How satisfied are you currently in the following areas?

- For items 10 – 21, mark the best response (1 for *Not Satisfied* through 5 for *Very Satisfied*).
- Which 3 items are most important to you? Under **3 Most Important**, write #1, #2 or #3 for the three areas that concern you most (#1=most important). Leave the other lines blank.
- For your 3 *Most Important* items, write the primary obstacles and barriers you face in the space beside that item

	Not Satisfied	Satisfied			Very Satisfied	3 Most Important	
10. Personal care and household activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
11. Physical comfort & well-being	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
12. Overall health	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
13. Freedom to go wherever desired	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
14. Participation in desired activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
15. Educational attainment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
16. Employment status/potential	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
17. Family relationships	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
18. Close, intimate relationships	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
19. Autonomy and self-determination (choosing)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
20. Fitting in, belonging, feeling connected	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____
21. Emotional well-being	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	_____	_____

C. Please mark all the statements below that describe you. Mark only those that *frequently or often* apply to you and ignore those that very *rarely or never* apply to you.

- | | | |
|---|--|---|
| <input type="checkbox"/> 22. I have the support I want from family | <input type="checkbox"/> 33. I am usually calm and patient | <input type="checkbox"/> 44. I find technology interesting |
| <input type="checkbox"/> 23. I have the support I want from friends | <input type="checkbox"/> 34. My life has purpose, meaning | <input type="checkbox"/> 45. I am cooperative |
| <input type="checkbox"/> 24. I feel encouraged by therapists, caregivers | <input type="checkbox"/> 35. I am self-disciplined | <input type="checkbox"/> 46. I prefer a quiet lifestyle |
| <input type="checkbox"/> 25. I feel the general public accepts me | <input type="checkbox"/> 36. I am often angry | <input type="checkbox"/> 47. I often feel isolated & alone |
| <input type="checkbox"/> 26. I aspire to go to school or work | <input type="checkbox"/> 37. I am often depressed | <input type="checkbox"/> 48. I accomplish what I set out to do |
| <input type="checkbox"/> 27. I have many things I want to accomplish | <input type="checkbox"/> 38. I prefer to be left alone | <input type="checkbox"/> 49. I am not sure who I am now |
| <input type="checkbox"/> 28. I do what my therapists say without question | <input type="checkbox"/> 39. I am often discouraged | <input type="checkbox"/> 50. I want more independence |
| <input type="checkbox"/> 29. I view my therapist(s) as friends, too | <input type="checkbox"/> 40. I am quite resourceful | <input type="checkbox"/> 51. I have a good self image |
| <input type="checkbox"/> 30. I am often frustrated or overwhelmed | <input type="checkbox"/> 41. I like having a challenge | <input type="checkbox"/> 52. I often feel insecure |
| <input type="checkbox"/> 31. I am curious & excited about new things | <input type="checkbox"/> 42. I am responsible & reliable | <input type="checkbox"/> 53. I feel as if I have little privacy |
| <input type="checkbox"/> 32. I am determined to meet my goals | <input type="checkbox"/> 43. I am generally satisfied with my life | <input type="checkbox"/> 54. My therapist(s) know better than I what I need |

D. COMMENTS:

Assistive Technology Device Predisposition Assessment

For Comparing Devices to Meet Desired Outcomes

Name _____ Form completed by _____
 Primary Goals (6 months) _____ Today's Date _____
 Primary Goals (1 year+) _____

DIRECTIONS: Write the name of each device you are considering in the boxes below under **Device**. An example has been provided. For each device, enter a [x] for the 3 items (A-L) that are most important to you. Then rate each device on the 12 items (A-L) according to the following scale and write your ratings in the appropriate boxes:

- 5 = All the time (100% of the time) 2 = Sometimes (around 25% of the time)
 4 = Often (around 75% of the time) 1 = Not at all (0% of the time)
 3 = Half the time, neutral (about 50% of the time) 0 = Not applicable

	Question	Example Quad Cane	Device 1: _____ (device name)	Device 2: _____ (device name)	Device 3: _____ (device name)
A	This device will help me to achieve my goals (including the primary AT goals written above).	5			
B	This device will benefit me and improve my quality of life.	3			
C	I am confident I know how to use this device and its various features.	x 4			
D	I will feel more secure (safe, sure of myself) when using this device.	x 5			
E	This device will fit well with my accustomed routine.	4			
F	I have the capabilities and stamina to use this device without discomfort, stress and fatigue.	x 3			
G	The supports, assistance and accommodations exist for successful use of this device.	4			
H	This device will physically fit in all desired environments (car, living room, etc.).	3			
I	I will feel comfortable (and <i>not</i> self-conscious) using this device around family.	4			
J	I will feel comfortable (and <i>not</i> self-conscious) using this device around friends.	4			
K	I will feel comfortable (and <i>not</i> self-conscious) using this device at school or work.	4			
L	I will feel comfortable (and <i>not</i> self-conscious) using this device around the community.	4			
	Total (add A-L)	47			

Review each **total score** above. In general, taking into account any items that were scored 0 for *Not applicable*, the device with the highest total score is the one most preferred (maximum number of points=60). However, when total scores are close, more weight should be given to the three items checked as being *most important*.

DEVICE SELECTED FOR TRIAL USE:

Vendor _____ Contact Person _____ Phone _____ Fax _____

Manufacturer _____ Style _____ Delivery Date: _____

Cost: _____ Payer: _____ Funding request notes: _____

How long device is expected to meet person's needs (Years) _____ (Months) _____ (Weeks) _____

COMMENTS AND NOTES:

Name _____

Form completed by _____

Device or System _____

Today's Date _____

A. Individual and Psychosocial INCENTIVES AND DISINCENTIVES TO ATD USE

Read each of the items below and decide which were incentives or disincentives/deterrents to the use of *this* assistive technology by *this* person. Then put an "X" in the appropriate box. For those that are neutral, do not apply to or **do not** exist in this situation, put an "X" in the middle box.



	Major Disincentive	Moderate Disincentive	Minor Disincentive	Neutral/Does Not Apply	Minor Incentive	Moderate Incentive	Major Incentive
1. Degree to which self-image has incorporated the disability	<input type="checkbox"/>						
2. View of barriers/limitations	<input type="checkbox"/>						
3. General life experiences	<input type="checkbox"/>						
4. Perceived control over quality of life	<input type="checkbox"/>						
5. Expectations of self	<input type="checkbox"/>						
6. Degree of social participation	<input type="checkbox"/>						
7. Socialization and social skills	<input type="checkbox"/>						
8. Expectations held by family	<input type="checkbox"/>						
9. Expectations held by friends	<input type="checkbox"/>						
10. Desire to go to work/school	<input type="checkbox"/>						
11. Cooperation with therapist and rehabilitation plan	<input type="checkbox"/>						
12. Interest in new things	<input type="checkbox"/>						
13. View of opportunities	<input type="checkbox"/>						
14. Attitude/outlook on life	<input type="checkbox"/>						
15. Mood and affect	<input type="checkbox"/>						
16. Degree of self-discipline and patience	<input type="checkbox"/>						
17. Desire to use technology(ies)	<input type="checkbox"/>						
18. Desire for independence	<input type="checkbox"/>						
19. Self-esteem	<input type="checkbox"/>						
20. Coping skills	<input type="checkbox"/>						
21. Exposure to technologies	<input type="checkbox"/>						
22. Degree of expressiveness	<input type="checkbox"/>						
Total Checked (for each column)							