GTS | GALLANT THERAPY SERVICES

Assistive Technology Questionnaire

Client Name:	DOB:	Contact Info:
Respondents Name:	Date of Referral:	Contact Info:

Directions: Please respond to relevant questions, and skip any that do not pertain to the client.

What would you like to see the client do that he or she cannot do now?

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_____

What are the barriers for the client to achieve functional participation in their daily lives?

_____

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_____

What assistive technology, supports, strategies, devices do they already have or have they tried?

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12 Shuman Ave., Suite 16, Augusta, ME 04330 Phone (207) 623-3900 Fax (207) 480-1541
20 East Ave., Unit 34, Lewiston, ME 04240 Phone (207) 509-0282 Fax (207) 716-4002
840 Kennedy Memorial Dr., Oakland, ME 04963 Phone (207) 716-1863 Fax (207) 716-4002
www.gallantttherapyservices.com

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Vision

Within Normal Limits ☐ Glasses ☐ Contacts ☐

Does the client have vision problems that affect their access to written material?

Mobility

The client is ambulatory ☐ Ambulatory with mobility aide ☐ Uses wheeled mobility ☐

Please list any mobile aids used currently:

Computer Skills

- ☐ Uses standard keyboard
- ☐ Uses Ipad or tablet
- ☐ Has apps that are used now
- ☐ Has tablet/Ipad
- ☐ Has cell phone
- ☐ Can read information on a computer screen

Communication

Verbal ☐ PECS ☐ iPad ☐ Eye Scanning ☐

Does the client currently use any communication tools?

Please described the clients current communication needs:

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Additional Information

Please include any other additional information that may be pertinent about the client here:

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Please return questionnaire to Alyssa MacDonald

Email: amacdonald@gallanttherapyservices.com

Mailing: 12 Shuman Avenue Suite 16 Augusta, ME 04330

Fax: 480-1541