



ISWP Mobility and Wheelchair Survey Guide

The International Society of Wheelchair Professionals (ISWP) is an international organization dedicated to professionalizing the field of wheelchair service provision. It is currently based at the University of Pittsburgh and funded by the United States Agency for International Development (USAID).

One of ISWP’s goals is to help service providers collect minimum data as it is essential to capture how they are contributing to improving wheelchair services and how collecting standard data can benefit service providers in terms of advocacy, training, products and evaluation.

Wheelchair service provision is the process through which and individual receives an appropriate wheelchair. The World Health Organization (WHO) has identified 8 steps that are fundamental in this process: 1. Referral. 2. Assessment. 3. Prescription. 4. Product Preparation. 5. Funding. 6. Fitting. 7. User Training. 8. Follow-up and Maintenance.

ISWP recommends service providers collect the following data points during wheelchair service and provision with clients. The survey should take between 7 and 10 minutes. Please know that all the responses are completely voluntary.

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: _____

For internal use only. Write in name of client for whom survey is completed. Service provider would provide an ID number to protect client info.

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

Write in address of where client resides most of the time

Town/District/Postal Code: _____ Country: _____

Write in town/district or community where client resides

Write in country where client resides

4. Wheelchair Clinic Name: _____

Write in name of wheelchair clinic or service provider

5. Wheelchair Clinic Address – Number and street: _____

Write in clinic or service provider address.

Town/District/Postal Code: _____ Country: _____

Write in town/district or community where clinic is located Write in country where clinic is located

6. Name of person at Wheelchair Clinic: _____

Write in first and last name of person at clinic who is working with client

7. Date completed: _____

Write in date survey was completed: day/month/year

8. Completed mostly by client Completed by caregiver/parent (*Check one*)

Put a check in the box next indicating who completed most of the survey

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

Put a check in the box next to the phrase that best describes the purpose of the visit on the date the survey was completed. While more than one reason could apply, please select the primary or most important reason.

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

If providing the person's name, please write in both first and last name. If providing the organization name, please write in the full name of the organization.

Demographics

11. Age/approximate age: _____ Not sure

Write in client age. Approximate age is fine. Put a check in the box next to “Not sure” if not sure.

12. What is your gender? Male Female No answer

Put a check in the box next to “Male” or “Female.” Put a check in the box next to “No answer” if prefer not to check either male or female.

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

Put a check in the box next to the highest level of education completed; please check only one answer or select “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

Put a check in the box next to the phrase that best describes employment status; check only one answer.

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

Put a check in the box next to all people with whom you live; multiple answers are accepted.

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

Write in the number of months or years you have needed help to walk or move and check whether the number represents months or years. If not sure, put a check in the box next to “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

Put a check in the box next to the primary reason you need help to walk or move.

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

Write in year of diagnosis or check “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>

Put a check in the box under the phrase that describes how difficult it is to walk a long distance, such as 100 meters, without the help of an item such as a walker or crutch.

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

Put a check in the box to indicate if you have someone helping when indoors – “Yes” – or do not have someone helping when indoors – “No.” If not sure, put a check in the box next to “Not sure.”

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

Put a check in the box to indicate if you have someone helping when outside – “Yes” – or do not have someone helping when outside – “No.” If not sure, put a check in the box next to “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 days 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

Put a check in the column next to each item currently owned. Then, for each item, put a check in the next column if it is used indoors and/or the following column if it is used outside. Then, put a check in the box for each item that has been used for more than one year. Multiple responses are accepted. Last, for each item, write in the number of days per week it is used (between 1 and 7) and number hours each day it is used (between 1 and 24).

<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>

Put a check in the box that best describes the level of difficulty pushing the current wheelchair. Consider the scale provided, where no difficulty means “I can push my wheelchair without any problems”, and severe difficulty means “I cannot push my own wheelchair.”

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

Check the box next to the one way used to push the wheelchair most often. If not sure, put a check in the box next to “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

Put a check in the box next to the most important reason for not pushing the wheelchair on your own. We understand there could be multiple reasons, but please think about and check the most important.

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.		

Please read each statement and put a check in the box under “Yes” or “No.”

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

Put a check in the box next to the approximate distance traveled each day in the wheelchair. If not sure, put a check in the box next to “Not sure.”

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

Put a check in the box next to “Yes” if you use public or private transportation to get from place to place. If you do not use public or private transportation, put a check in the box next to “No.” Check “Not sure” if you are not sure whether you use public or private transportation.

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): _____

Put a check in the box next to each type of transportation used at any time. If the type of transportation used is not listed, please put a check in the box next to Other and write in a description on the line next to Other.

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

Put a check in the box if you have ever fallen over in your wheelchair – “Yes.” If you have not fallen over, put a check in the box next to “No.” If you are not sure, put a check in the box next to “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

Put a check in the box next to the one answer that best describes who provided the wheelchair.

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.			

For each statement, put a check in the box under one of the phrases – whether you mostly agree with the statement, agree somewhat or do not agree at all.

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>

Put a check in the box that best describes how satisfied you are with your current wheelchair. The range is from “Not satisfied at all” to “Very satisfied.”

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

Put a check in the box if you received training described in the first column. If you did receive training, please write in an approximate number of hours in the last column. Put a check in the box next to “None” if you did not receive any training.

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)* _____

If information is easy to find on the item, please write in the manufacturer name, model or make, and serial number for each item used to help walk or move. If something is used that is not on list, please put a check in the box next to “Other” and write in a description on the line next to Other, using the additional line if you need more space.

Put a check in the box next to “None used currently” if none are used and a check in the box next to “Not sure” if not sure. If information is not available, please leave this question blank.

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"/>	a. Cushion with foam inside		
<input type="checkbox"/>	b. Cushion with gel inside		
<input type="checkbox"/>	c. Cushion with air inside		
<input type="checkbox"/>	d. Cushion, do not know what is inside		
<input type="checkbox"/>	e. Postural support device or devices		

Other, please describe: _____

- I do not use anything Not sure

If information is available and easy to find on the item, please put a check in the box next to each item in the first column – cushion or postural support device – that is used. Then, write in the manufacturer name and make or model or number for each item. If something else is used that is not listed, please put a check in the box next to “Other” and write in a description on the line next to Other.

If none of the items is used, put a check in the box next to “I do not use anything.” If not sure, put a check in the box next to “Not sure.” If information is not available, please leave this question blank.

You are finished with the survey.
 Thank you for your input.