CancerCare NORTHWEST™

Patient Name: _____

Account #: _____

In order to help us prepare for your initial visit, we ask that you complete the following mobility assessment.

1. Do you require assistance for any type of movement (walking, going to the restroom, getting out of a chair, getting on an exam table)?

   _____Yes_____No

   If yes, please explain: _____

   If not, thank you! You are done with this form. Please return it to front desk or nursing staff.

2. Do you have any visual or auditory impairment that affects your mobility?_____Yes_____No

   If yes, please explain: _____

3. Can you balance unassisted?

   Sitting_____Yes_____No

   Standing_____Yes_____No

4. Do you have upper body strength?_____Yes_____No

   If no, please explain: _____

5. Can you assist us in lifting your legs?_____Yes_____No

   If no, please explain: _____

6. Are you worried or concerned about falling?_____Yes_____No
7. Do you require any special equipment for mobility?_____ Yes_____No

   If yes, please explain: _____

PLEASE RETURN COMPLETED FORM TO FRONT DESK OR NURSING STAFF.