

Date _____

Subject ID # _____

Wheelchair Maintenance
Demographic Information

Name: _____

DOB: _____ / _____ / _____
(MM) (DD) (YY)

Phone: _____ (home) _____ (work)

Address:

Veteran: ____ (1) Yes
____ (0) No

Gender: ____ (1) Female
____ (0) Male

Ethnic Origin:

- ____ (1) African-American
- ____ (2) Asian American
- ____ (3) Caucasian
- ____ (4) Hispanic
- ____ (5) Other

Disability: _____

If Spinal Cord Injury, Please Indicate Level: _____

Date of Injury or Onset of Disability: _____ / _____ / _____
(MM) (DD) (YY)

Would you say your primary residence is in a rural or urban setting?

- ____ (1) Rural ____ (2) Urban ____ (3) Suburban

Wheelchair Questionnaire

The purpose of this questionnaire is to gain information regarding problems related to the functioning of your wheelchair. For this questionnaire, the definition of repairs includes anything that you or someone else would have to do so that the wheelchair functions properly, such as pumping up a flat tire, tightening a bolt or screw, having the frame welded.

1. Type of wheelchair that you use as your **PRIMARY** means of mobility (at least 1 time a week, for more than 4 hours at a time):

_____ 1. Manual →

1.a. How is your manual wheelchair propelled?

- _____ (1) "Standard" self-propelled
- _____ (2) Power Assist (power add-on, pushrim activated)
- _____ (3) Foot propelled
- _____ (4) Attendant Propelled ↴

1.b. What features does your attendant propelled wheelchair have?

- ___ (1) Manual tilt
- ___ (2) Power tilt
- ___ (3) No features
- ___ (4) Other _____

_____ 2. Power →

2.a. What kind of power base do you have?

Make: _____

Model: _____

2.b. What kind of seating system does your power wheelchair have? (**check all that apply**)

- ___ (1) Power recline
- ___ (2) Power tilt
- ___ (3) Power seat elevator
- ___ (4) Power leg elevator
- ___ (5) No features
- ___ (6) Other

_____ 3. Scooter →

3.a. What kind of features does your scooter have?

- ___ (1) Seat elevator
- ___ (2) No features
- ___ (3) Other

1A. What other kinds of accessories does your wheelchair have? (Please check all that apply.)

- _____ (1) Portable ventilator
- _____ (2) Side supports
- _____ (3) External controller parts (Sip-and-Puff, Chin controller)
- _____ (4) Power add on, such as Efix or Power Assist hubs
- _____ (5) Head joystick, head array

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2. Make (brand) of your primary wheelchair: (Please look at label on your wheelchair if unsure)

- ____ (1) Everest and Jennings
- ____ (2) Action/Invacare
- ____ (3) Sunrise/Quickie
- ____ (4) Permobil
- ____ (5) Pride
- ____ (6) Kuschall
- ____ (7) TiSport
- ____ (8) Otto Bock
- ____ (9) Other: Please list _____

3. Model of your primary wheelchair: _____
(Please look at label on your wheelchair if unsure)

4. Date of receipt of primary wheelchair: _____/_____/_____ (best guess if unknown)
Month / Date / Year

5. Is this your first wheelchair? ____ (1) Yes ____ (0) No

6. Type of wheelchair that you use as your **back-up wheelchair**:

- ____ (1) Manual
- ____ (2) Power
- ____ (3) Scooter
- ____ (4) Do not use or own a back-up wheelchair -> Please go to question 11.

7. Make (brand) of your back-up wheelchair (Please look at label on your wheelchair if unsure)

- ____ (1) Everest and Jennings
- ____ (2) Action/Invacare
- ____ (3) Sunrise/Quickie
- ____ (4) Permobil
- ____ (5) Pride
- ____ (6) Kuschall
- ____ (7) TiSport
- ____ (8) Otto Bock
- ____ (9) Other: Please list _____

8. Model of your back-up wheelchair: _____
(Please look at label on your wheelchair if unsure)

9. Date of receipt of back-up wheelchair: _____/_____/_____ (best guess if unknown)
Month / Date / Year

10. On average, how often do you use your back-up wheelchair?

- ____ (1) at least once a week
- ____ (2) several times a month
- ____ (3) several times a year

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The next set of questions refers to your primary wheelchair:

11. Were you evaluated for the wheelchair at a(n):

- _____ (1) Assistive Technology Clinic
- _____ (2) Rehabilitation Hospital/Clinic
- _____ (3) Direct Sales (Wheelchair or Medical Equipment Store)
- _____ (4) I was not evaluated for my wheelchair

12. Were you fitted for the wheelchair at a(n):

- _____ (1) Assistive Technology Clinic
- _____ (2) Rehabilitation Hospital/Clinic
- _____ (3) Direct Sales (Wheelchair or Medical Equipment Store)
- _____ (4) I was not evaluated for my wheelchair

13. Was your input part of the wheelchair selection process? ___ (1) Yes (0) ___ No

14.a. Who paid for this wheelchair? (*Please select primary source*)

- _____ (1) Employer-provided, Personal Health Insurance, Personal Disability Insurance, or Workers' Compensation
- _____ (2) Medicaid/Medicare
- _____ (3) VA
- _____ (4) Self or Family Member
- _____ (5) Other (please explain): _____

14.b. Were you responsible for any costs?

- _____ (0) No _____ (1) Yes



14.c. If Yes, what were they? _____

*For each of the next questions, please indicate your degree of satisfaction with each statement by placing an 'x' on the line. When answering the questions, please think of your **primary wheelchair**.*

Example:

No satisfaction _____ **X** _____ Very satisfied

15. *Overall*, how satisfied are you with your wheelchair?

Not satisfied _____ Very satisfied

16. How satisfied are you with the *durability* (sturdiness) of your wheelchair?

Not satisfied _____ Very satisfied

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17. How satisfied are you with the *simplicity* of use for your wheelchair?
Not satisfied _____ Very satisfied
18. How satisfied are you with the *comfort* of your wheelchair?
Not satisfied _____ Very satisfied
19. How satisfied are you with the *appearance* (design, form color) of your wheelchair?
Not satisfied _____ Very satisfied
20. How satisfied are you with the *dimensions* (convenience of height, width, length) of your wheelchair?
Not satisfied _____ Very satisfied
21. How satisfied are you with the *service delivery* (including prescription, delivery, follow up) of your wheelchair?
Not satisfied _____ Very satisfied
22. How satisfied are you with the *ease of transporting your wheelchair in a motor vehicle*?
Not satisfied _____ Very satisfied
23. How satisfied are you with the *fit* of your wheelchair to yourself?
Not satisfied _____ Very satisfied
24. How satisfied are you with the *customer service*?
Not satisfied _____ Very satisfied

25.a. Did you receive an owner's manual with your wheelchair?
____ (0) No ____ (1) Yes



25.b. IF YES, How satisfied are you with the *owners manual* you received with your wheelchair?

Not satisfied _____ Very satisfied

The next set of questions ask about the types of activities that you do while in your **primary** wheelchair.

26. How many hours a day do you spend in your wheelchair? _____ hours

27. How many hours a day do you actively propel or drive your wheelchair? _____ hours

28. How often do you travel over the following surfaces:

	Never (0)	Sometimes (1)	Often (2)	Always (3)
a. Sidewalk/Cement	_____	_____	_____	_____
b. Grass	_____	_____	_____	_____
c. Gravel	_____	_____	_____	_____
d. Dirt	_____	_____	_____	_____
e. Tile	_____	_____	_____	_____
f. Carpet	_____	_____	_____	_____
g. Curb cuts	_____	_____	_____	_____
h. Ramps	_____	_____	_____	_____

29. In general, how often is your primary wheelchair exposed to rain?

- _____ (0) Never, I live in a primarily dry climate.
- _____ (1) Never, when it rains, I do not go outside.
- _____ (2) Occasionally, once or twice a year.
- _____ (3) Sometimes, once or twice a month.
- _____ (4) The rain does not interfere with my daily outside activities.

30. In general, how often is your primary wheelchair exposed to snow?

- _____ (0) Never, I live in a warm climate
- _____ (1) Never, when it snows, I do not go outside.
- _____ (2) Occasionally, once or twice a year.
- _____ (3) Sometimes, once or twice a month, during the winter months.
- _____ (4) Often, at least once a week during the winter months.

31. Do you participate in physically active wheelchair sports?

- _____ (0) No
- _____ (1) Yes --> If yes, do you have a special wheelchair for sports?
 _____ (0) No ---> How much time is your primary wheelchair
 used for sports: _____ times per week
 _____ hours per time
 _____ (1) Yes

32. Do you travel outside your home area in which you have to render your wheelchair to baggage handlers?

____ (0) No

____ (1) Yes --> 31a. Please check the one that most accurately describes the frequency:

____ (0) At least once a week

____ (1) One to three times per month

____ (2) Two to three times a year

____ (3) Seldom (once a year at the most)

32. Do you receive regular maintenance on your primary wheelchair?

____ (0) No

____ (1) Yes --> How often? Please complete: Every _____ months.

33. Have you (or anyone) had to make any repairs (i.e. pump up flat tires, bolt/screw loosened, frame problems) to your primary wheelchair since you received it?

____ (0) No

____ (1) Yes

34. In the past 6 months, how many repairs/maintenance were needed to your wheelchair(s)? _____ IF this number is zero, thank you for your time.

IF number is greater than 0, please complete the information below, reporting only those repairs or maintenance visits that occurred in the past 6 months. Please check all the repairs that occurred on the same date.

REPAIR REPORT 1

A. Date of Repair: ____/____/____

(MM/DD/YY)

B. Chair: ____ (1) Primary ____ (2) Backup

C. Type of Repair: **Check as many as apply to date listed in Part A.**

____ (1) Electrical: Includes (**but not limited to**) problems with: _____

____ (2) Mechanical: Includes (**but not limited to**) problems with: _____

- Battery
- Joystick
- Control (box)
- Switches
- Etc.

- Drive motor
- Backrest
- Legrest
- Seat elevator
- Tilt in space
- Etc.

____ (3) Frame: Includes problems with frame itself **ONLY**.

____ (4) Adjustment: Including (**but not limited to**):

- Backrest Repositioning
- Armrest Repositioning
- Spoke Adjustment
- Brake Adjustment
- Etc.

____ (5) Tires/tubes: Including problems with:

- Casters
 - Bearings
 - Rims
- 5.a. Please specify which tire:
__ (1) Right __ (2) Left __ (3) Both

____ (6) New tires: Including:

- New/Replaced Tires
 - New/Replaced Tubes
- 6.a. please specify which tire:
__ (1) Right __ (2) Left __ (3) Both

____ (7) Any other new item: **For example**:

- New Backrest
- New Upholstery
- ANYTHING BUT TIRES
- Etc.

____ (8) Accessories: Including (**but not limited to**) repairs to:

- Cushion
- Clothing guards
- Side supports
- Portable ventilator attachments
- External controls
- Etc.

____ (9) General Maintenance: Including (**but not limited to**):

- Cleaning
- Lube
- Etc.

____ (10) Other: Please explain.

D. Who completed these repairs? Check all that apply

- ____ (1) Self/Family Member/Caregiver ____ (2) Technician/ Service Provider
 ____ (3) Bike shop ____ (4) Other, please specify: _____

E. Was the problem fixed? ____ (1) Yes ____ (0) No

F. Were you injured as a result of the problem with the wheelchair?

- ____ (1) Yes ____ (0) No

↓

F.1. If yes, please check all that apply:

____ 1. Scrapes

____ 2. Cuts

____ 3. Bruises/ bumps

____ 4. Ligament sprain/strain

____ 5. Fractures

____ 6. Other _____

G. Was there a cost to anyone associated with these repairs?

- ____ (1) Yes ____ (0) No

↓

Who paid for this repair?

____ (1) Employer-provided, Personal Health Insurance, Personal Disability Insurance, or Workers' Compensation

____ (2) Medicaid/Medicare

____ (3) VA

____ (4) Vocational Rehabilitation

____ (5) Self or Family Member → Cost: \$ _____

____ (6) Other (please explain): _____

REPAIR REPORT 2

A. Date of Repair: ____/____/____
(MM/DD/YY)

B. Chair: ____ (1) Primary ____ (2) Backup

C. Type of Repair: **Check as many as apply to date listed in Part A.**

____ (1) Electrical: Includes (**but not limited to**) problems with: →

____ (2) Mechanical: Includes (**but not limited to**) problems with:

- Battery
- Joystick
- Control (box)
- Switches
- Etc.

- Drive motor
- Backrest
- Legrest
- Seat elevator
- Tilt in space
- Etc.

____ (3) Frame: Includes problems with frame itself **ONLY**.

____ (4) Adjustment: Including (**but not limited to**):

- Backrest Repositioning
- Armrest Repositioning
- Spoke Adjustment
- Brake Adjustment
- Etc.

____ (5) Tires/tubes: Including problems with:

- Casters
 - Bearings
 - Rims
- 5.a. Please specify which tire:
 __ (1) Right __ (2) Left __ (3) Both

____ (6) New tires: Including:

- New/Replaced Tires
 - New/Replaced Tubes
- 6.a. please specify which tire:
 __ (1) Right __ (2) Left __ (3) Both

____ (7) Any other new item: **For example:**

- New Backrest
- New Upholstery
- ANYTHING BUT TIRES
- Etc.

____ (8) Accessories: Including (**but not limited to**) repairs to:

- Cushion
- Clothing guards
- Side supports
- Portable ventilator attachments
- External controls
- Etc.

____ (9) General Maintenance: Including (**but not limited to**):

- Cleaning
- Lube
- Etc.

____ (10) Other: Please explain.

D. Who completed these repairs? Check all that apply

____ (1) Self/Family Member/Caregiver

____ (2) Technician/ Service Provider

____ (3) Bike shop

____ (4) Other, please specify: _____

E. Was the problem fixed? ____ (1) Yes

____ (0) No

F. Were you injured as a result of the problem with the wheelchair?

____ (1) Yes

____ (0) No

F.1. **If yes**, please check all that apply:

____ 1. Scrapes

____ 2. Cuts

____ 3. Bruises/ bumps

____ 4. Ligament sprain/strain

____ 5. Fractures

____ 6. Other _____

H. Was there a cost to anyone associated with these repairs?

___ (1) Yes ___ (0) No



Who paid for this repair?

___ (1) Employer-provided, Personal Health Insurance, Personal Disability Insurance, or Workers' Compensation

___ (2) Medicaid/Medicare

___ (3) VA

___ (4) Vocational Rehabilitation

___ (5) Self or Family Member → Cost: \$ _____

___ (6) Other (please explain): _____

REPAIR REPORT 3

B. Date of Repair: ___/___/___
(MM/DD/YY)

B. Chair: ___ (1) Primary ___ (2) Backup

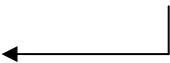
C. Type of Repair: **Check as many as apply to date listed in Part A.**

___ (1) Electrical: Includes (**but not limited to**) problems with: →

___ (2) Mechanical: Includes (**but not limited to**) problems with:

- Battery
- Joystick
- Control (box)
- Switches
- Etc.

- Drive motor
- Backrest
- Legrest
- Seat elevator
- Tilt in space
- Etc.



___ (3) Frame: Includes problems with frame itself **ONLY**.

___ (4) Adjustment: Including (**but not limited to**):

- Backrest Repositioning
- Armrest Repositioning
- Spoke Adjustment
- Brake Adjustment
- Etc.

____ (5) Tires/tubes: Including problems with:

<ul style="list-style-type: none">▪ Casters▪ Bearings▪ Rims <p>5.a. Please specify which tire: __ (1) Right __ (2) Left __ (3) Both</p>

____ (6) New tires: Including:

<ul style="list-style-type: none">▪ New/Replaced Tires▪ New/Replaced Tubes <p>6.a. please specify which tire: __ (1) Right __ (2) Left __ (3) Both</p>

____ (7) Any other new item: **For example:**

<ul style="list-style-type: none">▪ New Backrest▪ New Upholstery▪ ANYTHING BUT TIRES▪ Etc.

____ (8) Accessories: Including (**but not limited to**) repairs to:

<ul style="list-style-type: none">▪ Cushion▪ Clothing guards▪ Side supports▪ Portable ventilator attachments▪ External controls▪ Etc.
--

____ (9) General Maintenance: Including (**but not limited to**):

<ul style="list-style-type: none">▪ Cleaning▪ Lube▪ Etc.
--

____ (10) Other: Please explain.

D. Who completed these repairs? **Check all that apply**

- (1) Self/Family Member/Caregiver
- (2) Technician/ Service Provider
- (3) Bike shop
- (4) Other, please specify: _____

E. Was the problem fixed? (1) Yes (0) No

F. Were you injured as a result of the problem with the wheelchair?

- (1) Yes
- (0) No

↓

F.1. If yes, please check all that apply:

- 1. Scrapes
- 2. Cuts
- 3. Bruises/ bumps
- 4. Ligament sprain/strain
- 5. Fractures
- 6. Other _____

I. Was there a cost to anyone associated with these repairs?

- (1) Yes
- (0) No

↓

Who paid for this repair?

- (1) Employer-provided, Personal Health Insurance, Personal Disability Insurance, or Workers' Compensation
- (2) Medicaid/Medicare
- (3) VA
- (4) Vocational Rehabilitation
- (5) Self or Family Member → Cost: \$ _____
- (6) Other (please explain): _____

If there have been more than three dates on which your wheelchair needed repairs or general maintenance, please check here- _____ YOU WILL BE CONTACTED BY PHONE!!!

THANK YOU FOR YOUR TIME TO COMPLETE THIS QUESTIONNAIRE!