STATE OF NEW JERSEY
DEVELOPMENTAL DISABILITIES
PHYSICAL THERAPY ASSESSMENT FORM (PTAF)

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Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Consumer Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE CONSUMER.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE CONSUMER'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

1. Please provide information on the **consumer's medical status** by completing the following 3 sections as described below.

   A. Please circle whether or not the consumer has had the following **DIAGNOSED** condition or illness in the **last 2 years**.

   B. **ONLY IF CONSUMER HAS CURRENT DIAGNOSIS,** circle whether consumer has seen or been reviewed by a doctor during the **last 3 months SPECIFICALLY** for this condition.

   C. **ONLY IF CONSUMER HAS CURRENT DIAGNOSIS,** circle whether **THIS CONDITION** needs medical attention by a doctor **more often than once per year**.

			IF HAS CONDITION(S), ANSWER BOTH			
	A. Has Condition?		B. Seen or Reviewed by Doctor in the **Last 3 Months** for this Condition?		C. Condition Needs Medical Attention **More Than Yearly**?	
	NO	YES	NO	YES	NO	YES
Muscular-Skeletal Conditions such as muscular difficulties with the arms and/or legs, arthritis, osteoporosis?	0	1	0	1	0	1

2. Which best describes the consumer's **mobility** with each of the following tasks in the **last 4 weeks**?

	NOT ABLE	NEEDED HELP	INDEPENDENTLY
a. Rolling from back to stomach	0	1	2
b. Pulling self to standing	0	1	2
c. Going up stairs	0	1	2
d. Going down stairs	0	1	2
e. Picking up small objects	0	1	2
f. Transferring an object from hand to hand	0	1	2
g. Crawling, creeping, or scooting such as getting something from under a bed or chair	0	1	2
h. Sitting without support such as on a stool or piano bench for at least 5 minutes	0	1	2

3. Which answer **best** describes the consumer's level of **walking** mobility in the **last 4 weeks**?

0. Can not walk by self or with assistance
1. Walks only with assistance from another person (with or without a corrective device)
2. Walks independently with corrective device (walker, crutches, brace)
3. Walks independently, but with difficulty (no corrective device)
4. Walks independently

4. Does the consumer use a wheelchair or electric scooter?

0. Yes, uses at all times (if yes, go to question #5)
1. Yes, uses for long trips or as needed (if yes, go to question #5)
2. No, does not use (if no, go to question #8)

5. Please indicate which of the following have been used by the consumer in the **last 4 weeks.**

IF PRESCRIBED, BUT NOT USED BY CONSUMER IN THE LAST 4 WEEKS, ANSWER "NO."

		NO	YES
a.	Non-motorized Wheelchair	0	1
b.	Motorized Wheelchair	0	1
c.	Electric Scooter	0	1

6. Which answer **best** describes the consumer's ability to **transfer himself/herself** in or out of the wheelchair/scooter?

0. Regularly required the use of a hoyer or other lift and/or more than one other person when transferring
1. Needs a lot of physical assistance from or to be lifted by one other person when transferring
2. Needs only minimal assistance from one other person when transferring
3. Can transfer independently without assistance

7. Which **best** describes the consumer's ability to **move his/her wheelchair/scooter** from place to place?

0. Has no independent wheelchair mobility – needs someone to push him/her from place to place
1. Can move wheelchair back and forth with hands or feet, but requires pushing to move from place to place for any real distance
2. Can move wheelchair independently from place to place without assistance, but requires pushing for long distances
3. Can move wheelchair independently from place to place without assistance and requires no assistance even for longer distances

		NO	YES
8.	Please indicate whether the consumer has received physical therapy in the **last 3 months** in any setting.	0	1

9. Regardless of where the consumer lives, what services might be necessary, if any, from a physical therapist?

    1. None Needed
    2. Needed on an Occasional Basis
    3. Needed on a Frequent Basis

10. Please indicate any **adaptive or special equipment** that the consumer used at any time in the l**ast 3 months**.

IF PRESCRIBED, BUT NOT USED BY CONSUMER IN THE LAST 3 MONTHS, ANSWER "NO."

		NO	YES
a.	Walker?	0	1
b.	Crutches or cane?	0	1
c.	Brace/splint?	0	1
d.	Prescribed orthotics or prescribed orthopedic shoes?	0	1
e.	Special Bed or Bed Modifications? (e.g., side rails, special mattress, elevation)	0	1

Thank you for your assistance!