

Jamie Arasz Prioli, RESNA ATP

“Assistive Technology for All Abilities”
990 Cedar Bridge Ave. Suite B7 - #204 Brick, New Jersey 08723-4157
Phone: 732-331-5379 www.japriolisolutions.com

Assistive Technology Pre-Assessment Survey

Please complete the following questionnaire and return the survey to the above mailing address or email the survey to info@japriolisolutions.com. The more information you can provide about the recipient of the assessment, the more through an assessment we can make.

Your time and effort in completing this survey is greatly appreciated!

Name: _____

Date: _____

Age: _____

DOB: _____

Parents (if under 18) _____

Phone: _____

Address: _____

Email: _____

Medical Diagnosis: _____

Assistive Technology Currently Using: _____

Educational Classification (if appropriate): _____

Grade: _____

Mainstream: _____

Self-contained: _____

Resource Room: _____

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Reason for Referral (please check as appropriate)

Organization Difficulty Using a Computer Handwriting (Fatigue, Sloppiness, etc.)

Reading Study Skills Composing written material

Home Accessibility Environmental Access Daily Scheduling

Other – Please list specific vocational, educational, or independent living goals you would like to meet _____

I. Computer Experience

Currently uses a computer _____ Yes _____ No

If yes, what type of computer? (Please check all that apply)

Desktop/Tower Laptop Hand-held (Palm, etc.)

Other _____

What operating system(s) are you currently using? (Please check all that apply)

Windows XP Windows Vista Windows 2000/ME

Windows 98 Mac OS 10 Mac OS9 or below

Other _____

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How is the computer accessed? (Please check all that apply)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Standard keyboard | <input type="checkbox"/> Mouse | <input type="checkbox"/> Mouth Stick |
| <input type="checkbox"/> Ergonomic Keyboard | <input type="checkbox"/> Trackball | <input type="checkbox"/> Head Pointer |
| <input type="checkbox"/> Intellikeys Keyboard | <input type="checkbox"/> Trackpad/Touchpad | <input type="checkbox"/> Head Mouse |
| <input type="checkbox"/> Voice Activation | <input type="checkbox"/> Mini Keyboard | <input type="checkbox"/> Touch Window |
| <input type="checkbox"/> Keyboard with Keyguard | <input type="checkbox"/> Joystick | <input type="checkbox"/> Switch |
| <input type="checkbox"/> Scanning with Switch (*) | <input type="checkbox"/> Other Adapted Keyboard_____ | |
| <input type="checkbox"/> Other_____ | | |

(*) Switch users, please describe the kind of switch used, how you access it, and where / how it is mounted

If you use a standard keyboard, which of the following apply (Please check all that apply):

- Trouble hitting the correct keys
- Want to type faster
- Uses one hand to type - RIGHT or LEFT (please circle one)
- Cannot reach all keys on the keyboard
- Holds down the keys too long and repeat keys unintentionally
- Easily tires when typing

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V. Mobility

- Walks Independently
- Walks with assistance (orthotics, crutches, walker, etc.)
- Uses a manual wheelchair (Model _____)
- Uses a power wheelchair (Model _____)

VI. Fine Motor

- Uses both hands
- Uses one hand _____right _____left
- Can point
- Finger dexterity – Weak Fair Good (circle one)
- Hand tremors

VII. Additional Information

Currently receiving the following therapies:

- Speech / Communication Frequency: _____
- Physical Therapy Frequency: _____
- Occupational Therapy Frequency: _____
- Cognitive Therapy Frequency: _____
- Other Frequency: _____

