Functional Mobility Assessment Sheet

Patient Name

Date of Assessment

ID Number

Assessor Name

Contact

Mobility Assessment

Functional Area	Independent	Needs Assist	Dependent	Notes
Bed Mobility	☐	☐	☐	
Transfers	☐	☐	☐	
Ambulation	☐	☐	☐	
Wheelchair Mobility	☐	☐	☐	
Stair Navigation	☐	☐	☐	

Assistive Devices Used

e.g., Walker, Cane, Wheelchair

Environmental Barriers

Pain or Discomfort Noted

Comments / Recommendations

Signature

Date