Computer Technology Assessment

Individual's Name:_____

	Yes	No	Comments
Is able to use a traditional keyboard? If yes, does it cause pain?	☐	☐	
Has the manual dexterity to control the mouse?	☐	☐	
Is able to see the computer screen? If yes, does it cause discomfort?	☐	☐	
Has the ability to operate a computer? (turning computer on/off, handling disks, paper, etc.)	☐	☐	
Is knowledgeable and able to perform basic tasks on computer? (typing, editing, e-mailing, etc.)	☐	☐	
Is currently utilizing any assistive technology for the computer? Please specify.	☐	☐	
Can individual type at least 35 words/minute? Please specify typing speed.	☐	☐	
Is individual knowledgeable and able to use Microsoft Office Programs? Please specify.	☐	☐	
Other:			

Medical/disability restrictions that would affect this individual's ability to operate the computer:

Potential Computer Adaptations/Recommendations/Evaluations:

Assistive Technology:

Sensory Aids:

Other:

Training:

Basic Computer Applications:

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Use of Adaptive Equipment:

Other:

Equipment:

Alternate Mouse:

Alternate Keyboard:

On-Screen Keyboard:

CCTV:

Large Computer Screen:

Adjustable Furniture:

Adaptive Software:

Clear Form

Computer Technology Assessment

Voice Input/Output:

Braille Writer:

Other:

EC Name: _____ Date: _____

Clear Form