Gillette Children's
Specialty Healthcare

Initial Functional Assessment Questionnaire

Patient Name:
D.O.B:
ACCT#:
MR#:

James R. Gage Center for Gait and Motion Analysis

Thank you for your assistance. If you need help or have any questions, please contact the Center for Gait and Motion Analysis Staff at (651) 229-3868.

1. **Patient's Name:** _____
First Middle Last

2. **Date of scheduled analysis:** _____ 3. **Today's date:** _____

4. **Your relationship to the patient:**
- ❑ I am the patient
- ❑ Patient's mother
- ❑ Patient's father
- ❑ Foster parent
- ❑ Other caregiver _____
- ❑ Other relationship _____

5. **Patient's grade in school:**
- ❑ Not in school
- ❑ Pre-school or daycare
- ❑ Kindergarten
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10
- ❑ 11
- ❑ 12
- ❑ College or University
- ❑ Technical or vocational training
- ❑ Other: _____

6. **What are your particular concerns regarding the patient's walking?**

_____

_____

_____

7. List specific goals or expectations you may have for treatment:

_____

_____

_____

Patient's Medical History:

1. **Does the patient have a seizure disorder?** ❑ Yes ❑ No
   1a. If yes, is medication used for seizure control? ❑ Yes ❑ No
   1b. If yes, please list medication (s): _____

2. **Does the patient have learning or behavioral issues?** ❑ Yes ❑ No
   2a. If yes, is medication used for learning or behavior issues? ❑ Yes ❑ No
   2b. If yes, please list medication (s): _____

3. **Is the patient currently on medication to control spasticity?** ❑ Yes ❑ No
   3a. If yes, please list medication (s): _____

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Patient's Birth History:

1. **How much did the patient weigh at birth?** _____ pounds _____ Ounces

2. **Was this patient born early or late?** ❑ Yes ❑ No
   a. If yes, how many weeks early? _____ How many weeks late? _____

3. **Was this patient a product of a multiple birth (twins, triplets)?** ❑ Yes ❑ No
   3a. If yes, the patient was born (please circle) 1st 2nd 3rd

4. **Were there any problems during the pregnancy?** ❑ Yes ❑ No ❑ Unknown
   4a. If yes, please check all the problems during pregnancy.
   - ❑ a. No prenatal care
   - ❑ b. Bleeding
   - ❑ c. Severe high blood pressure, swelling, and kidney problems watched by your doctor (toxemia)
   - ❑ d. Mother and child had different blood type that caused a problem (Rh incompatibility)
   - ❑ e. Infection or virus that was passed to the baby
   - ❑ f. Premature labor that was stopped
   - ❑ g. Incompetent cervix
   - ❑ h. Onset of premature labor (premature rupture of the membranes)
   - ❑ i. Placenta implantation at or near the opening of the cervix (placenta previa)
   - ❑ j. Other problems, please describe: _____

5. **Were there any problems during the delivery and the birth of the patient?** ❑ Yes ❑ No ❑ Unknown
   5a. If yes, please check all the problems during the delivery and birth.
   - ❑ a. Labor greater than 24 hours
   - ❑ b. Lack of oxygen to the baby
   - ❑ c. Baby was sideways or feet first (breech delivery)
   - ❑ d. High forceps used in delivery
   - ❑ e. Early separation of placenta (placenta abruptio)
   - ❑ f. Scheduled C-section for: _____
   - ❑ g. Emergency C-section for: _____
   - ❑ h. Other, please describe: _____

6. **Did this patient have any medical problems right after birth?** ❑ Yes ❑ No ❑ Unknown
   6a. Was your child in a neonatal intensive care unit (NICU) after birth? ❑ Yes ❑ No
   If yes, how long? _____
   6b. Was your child on a ventilator after birth? ❑ Yes ❑ No
   If yes, how long? _____

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6c. If yes to question 6, please check all the medical problems this patient had right after he/she was born.

- ❑ a. Seizures
- ❑ b. Bleeding in the brain (hemorrhage)
- ❑ c. Breathing problems (bronchopulmonary dysplasia, hyaline membrane disease etc.)
- ❑ d. Brain or spinal cord infection (central nervous system infection)
- ❑ e. Periods when breathing would stop (apnea)
- ❑ f. Fluid on the brain (hydrocephalus)
- ❑ g. Lack of oxygen at birth (anoxia)
- ❑ h. Jaundice (hyperbilirubinemia)
- ❑ i. Intestinal problems (necrotizing enterocolitis)
- ❑ j. Aspiration (fluid in the lungs, meconium aspiration)
- ❑ k. Slow heart beat (bradycardia)
- ❑ l. Patent ductus arteriosis (PDA)
- ❑ m. Other: _____

7. **At what age did the patient (with the help of braces, crutches, or walker, if needed) begin to:** **Child's Age**
   a. Take first steps _____
   b. Walk around steadily _____

7a. What assistive devices did the patient use to begin walking:

❑ None ❑ Crutches ❑ Walker

8. **At what age was the patient when:** **Child's Age**
   a. You first thought he/she had problems with his/her movements that were later determined to be part of his/her diagnosis? _____
   b. You first talked to a doctor about these problems? _____
   c. His/her disability was first diagnosed? _____
   d. He/she began a physical therapy program? _____

9. **How would you describe the movement problems the patient was having when you first noticed them?**

_____

_____

_____

_____

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10. **Please list any surgical procedures or treatments the patient has had related to his/her gait or walking** (for example, lower extremity surgery, upper extremity surgery, spine surgery, Botox, Rhizotomy, and/or Baclofen pump).

Date **Type of treatment or surgical procedure**

Patient's Physical Abilities (this section pertains to the patient's transferring and walking abilities):

1. **Please choose *one* statement that best describes the patient's usual or typical walking abilities** (with assistive devices typically used).
This patient:

- ❑ 1. Cannot take any steps at all.
- ❑ 2. Can do some stepping on his/her own with the help of another person. Does not take full weight on feet; does not walk on routine basis.
- ❑ 3. Walks for exercise in therapy and /or less than typical household distances.
- ❑ 4. Walks for household distances, but makes slow progress. Does not use walking at home as preferred mobility (primarily walks in therapy or as exercise).
- ❑ 5. Walks for household distances routinely at home and/or school. Indoor walking only.
- ❑ 6. Walks more than 15-50 feet outside the home but usually uses a wheelchair or stroller for community distances or in congested areas.
- ❑ 7. Walks outside for community distances, but only on level surfaces (cannot perform curbs, uneven terrain, or stairs without assistance of another person).
- ❑ 8. Walks outside the home for community distances, is able to get around on curbs and uneven terrain in addition to level surfaces, but usually requires minimal assistance or supervision for safety.
- ❑ 9. Walks outside the home for community distances, easily get around on level ground, curbs, and uneven terrain but has difficulty or requires minimal assistance or supervision with running, climbing, and/or stairs. Has some difficulty keeping up with peers.
- ❑ 10. Walks, runs, and climbs on level and uneven terrain and does stairs without difficulty or assistance. Is typically able to keep up with peers.

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2. **Please rate how easy it is for the patient to do the following activities** *(with assistive devices typically used).*

	Easy	A little hard	Very hard	Can't do at all	Too young for activity
Walk carrying an object	O	O	O	O	O
Walk carrying an fragile object or glass of liquid	O	O	O	O	O
Walk up and down stairs using the railing	O	O	O	O	O
Walk up and down stairs without using the railing	O	O	O	O	O
Steps up and down curb independently	O	O	O	O	O
Runs	O	O	O	O	O
Runs well including around a corner with good control	O	O	O	O	O
Can take steps backwards	O	O	O	O	O
Can maneuver in tight areas	O	O	O	O	O
Get on and off a bus by him/herself	O	O	O	O	O
Jump rope	O	O	O	O	O
Jumps off a single step independently	O	O	O	O	O
Hop on right foot *(without holding onto equipment or another person)*	O	O	O	O	O
Hop on left foot *(without holding onto equipment or another person)*	O	O	O	O	O
Step over an object, right foot first	O	O	O	O	O
Step over an object, left foot first	O	O	O	O	O
Kick a ball with right foot	O	O	O	O	O
Kick a ball with left foot	O	O	O	O	O
Ride 2 wheel bike *(without training wheels)*	O	O	O	O	O
Ride 3 wheel bike *(or 2 wheel bike with training wheels)*	O	O	O	O	O
Ice skate or roller skate *(without holding onto another person)*	O	O	O	O	O
Can step on/off an escalator and ride without help	O	O	O	O	O

3. **Does the patient trip or stumble more often than typical for age/level of activity?** ❑ Yes ❑ No ❑ No, because of constant supervision

3a. If yes, how often? ❑ 1x/month ❑ 1x/week ❑ 1-2x/day ❑ Multiple times/day

4. **Does the patient fall more often than typical for age/level of activity?** ❑ Yes ❑ No ❑ No, because of constant supervision

4a. If yes, how often? ❑ 1x/month ❑ 1x/week ❑ 1-2x/day ❑ Multiple times/day

5. **In your opinion, rate how the following limit the patient's walking ability.**

	Never	Sometimes	About half the time	Often	All the time
Pain **(if patient has pain, please also answer question 6**)	O	O	O	O	O
Weakness	O	O	O	O	O
Endurance, tolerance, or strength	O	O	O	O	O
Mental ability (such as lack of concentration or awareness)	O	O	O	O	O
Safety concerns	O	O	O	O	O
Balance	O	O	O	O	O
Other	O	O	O	O	O

Please describe: _____

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6. **Indicate the location of the pain and when it occurs. Please check all that apply:**

	R=Right	**L**=Left	**B**=Both	**Beginning or End of Day**	**Walking Short Distances**	**Prolonged Walking**	**Standing**	Stairs or Uneven Terrain	**Constant Pain Not Activity Related**
Back	lower	upper	both	O	O	O	O	O	O
Hips	☐ R	☐ L	☐ B	O	O	O	O	O	O
Knees	☐ R	☐ L	☐ B	O	O	O	O	O	O
Ankles	☐ R	☐ L	☐ B	O	O	O	O	O	O
Feet	☐ R	☐ L	☐ B	O	O	O	O	O	O
Other :				O	O	O	O	O	O

Please describe: _____

7. **Is the patient currently involved in a physical therapy program?** ❑ Yes ❑ No

If yes, please answer the following questions.

7a. Which of the following best describes the type of physical therapy program?

- ❑ a. School program with treatment provided by a licensed physical therapist
- ❑ b. School program with treatment provided by an aid or other school staff
- ❑ c. Adaptive physical education at school
- ❑ d. Hospital or outpatient center program provided by a licensed physical therapist
- ❑ e. Home based program by a licensed physical therapist
- ❑ f. Home exercise program only
- ❑ g. Combination of the above. Please describe:_____

_____

- ❑ h. Other please describe:

_____

7b. How often does the patient usually participate in a therapy type program including exercising at home?

- ❑ a. Daily
- ❑ b. 4-6 times a week
- ❑ c. 3 times a week
- ❑ d. 2 times a week
- ❑ e. 1 time a week
- ❑ f. 2 times a month
- ❑ g. 1 time a month
- ❑ h. Beginning and end of school year
- ❑ i. Never
- ❑ j. Other, please describe:

_____

7c. How often does the patient see a licensed physical therapist for evaluation, consultation, or treatment?

- ❑ a. Daily
- ❑ b. 4-6 times a week
- ❑ c. 3 times a week
- ❑ d. 2 times a week
- ❑ e. 1 time a week
- ❑ f. 2 times a month
- ❑ g. 1 time a month
- ❑ h. Beginning and end of school year
- ❑ i. Never
- ❑ j. Other, please describe:

Thank you very much for taking the time to complete this questionnaire.