



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?
1a. If yes, is medication used for seizure control?
1b. If yes, please list medication (s):
2. Does the patient have learning or behavioral issues?
2a. If yes, is medication used for learning or behavior issues?
2b. If yes, please list medication (s):
3. Is the patient currently on medication to control spasticity?
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 arteriosus (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

Horizontal lines for age input

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?

Horizontal lines for age input

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

Horizontal lines for text input



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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

Multiple horizontal lines for data entry.

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walk carrying an fragile object or glass of liquid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walk up and down stairs using the railing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walk up and down stairs without using the railing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Steps up and down curb independently	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Runs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Runs well including around a corner with good control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Can take steps backwards	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Can maneuver in tight areas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Get on and off a bus by him/herself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jump rope	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jumps off a single step independently	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hop on right foot (<i>without holding onto equipment or another person</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hop on left foot (<i>without holding onto equipment or another person</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Step over an object, right foot first	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Step over an object, left foot first	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kick a ball with right foot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kick a ball with left foot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ride 2 wheel bike (<i>without training wheels</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ride 3 wheel bike (<i>or 2 wheel bike with training wheels</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ice skate or roller skate (<i>without holding onto another person</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Can step on/off an escalator and ride without help	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endurance, tolerance, or strength	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental ability (such as lack of concentration or awareness)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safety concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Balance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hips	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knees	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ankles	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feet	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other :				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.