Gillette Children's
Specialty Healthcare

Follow-Up 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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4. **Has the patient had any surgical procedures or treatments related to his/her gait or walking** (for example, lower extremity surgery, upper extremity surgery, spine surgery, Botox, Rhizotomy, and/or Baclofen pump) since their last visit to the Gait Lab? ❑ Yes ❑ No

5. **If yes, please list in the space below.**

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: _____

If your child has not had surgery since his last visit to the Center for Gait and Motion Analysis please skip the next section. Go to the section on Physical Therapy and continue.

Surgical outcome:

1. **Please rate the following comparing from before to after surgical intervention:**

	Increased	Decreased	No Change	Not Applicable
Pain	O	O	O	O
Strength	O	O	O	O
Endurance	O	O	O	O
Ability to keep up with friends	O	O	O	O

2. **What effect did the surgery have for the patient in the following areas?**

	Helped	Hindered	No effect
Self Esteem	O	O	O
Mobility	O	O	O
Social/Peer Interactions	O	O	O
Independence	O	O	O
Body Image	O	O	O

3. **Please list any skills the patient has gained after his/her surgery**
(for example, he/she can now get up and down off the floor without help).

_____

_____

_____

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4. **Please list any skills that your child has lost after surgery**
(for example, he/she no longer is able to get up and down off the floor by his/herself).

For Parents or Adult Patients answer 5 and 6

5. **Were your expectations for surgery met?** (please circle):
Definitely Yes Probably Yes Not Sure Probably Not Definitely Not
Please explain:

6. **Were the results of surgery worth the difficulties? Would you do it again?**
(please circle):
Definitely Yes Probably Yes Not Sure Probably Not Definitely Not
Please explain:

For Parent or Caregiver

7. **Overall, your feeling towards the result of the surgery is** (please circle):
Extremely satisfied Satisfied Neutral Dissatisfied Extremely dissatisfied
Please explain:

For patient

8. **Overall, my feeling towards the results of the surgery is** (please circle):
Extremely satisfied Satisfied Neutral Dissatisfied Extremely dissatisfied
Please explain:

If the patient is unable to complete this question, please mark here. O

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Physical Therapy Program:

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

If yes, please answer the following questions.

A. 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:

_____

B. 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:

_____

C. 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.