HISTORY QUESTIONNAIRE
for MOTION ANALYSIS

Please complete as thoroughly and accurately as possible.

Patient’s name: ______________________________
Date of birth: ______________________________
Date of next physician appointment: ______________

What is your relationship to the patient?
□ Self (adult)  □ Foster parent
□ Patient’s mother  □ Patient’s stepmother
□ Patient’s father  □ Patient’s stepfather
□ Caregiver (____________________)
□ Other (____________________)
□ Do you have legal guardianship?  □ Yes  □ No  □ N/A

BIRTH/ DEVELOPMENTAL HISTORY
Was patient born prematurely?  □ Yes  □ No
If yes, how early? _______
How was the patient delivered? □ Vaginal  □ C-section  □ Forceps  □ Vacuum
What was the patient’s birth weight? _______
What were the patient’s Apgar scores? _____1 min. _____5 min.  □ Unknown
Did the patient spend time in a neonatal intensive care unit? □ Yes  □ No
If yes, for how long? _______________________
Was the patient on a ventilator? □ Yes  □ No
If yes, for how long? _______________________
Were there any major issues or concerns during the NICU stay? _______________________

At what age was the patient first able to consistently walk across a room independently without any support? _______
□ Currently unable
SURGICAL HISTORY
Please list any relevant surgeries that the patient has undergone (for example, orthopedic or neurologic surgeries involving the hip, leg, foot, or spine).

☐ Check here if Not Applicable

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<th>Date</th>
<th>Procedure(s):</th>
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MEDICATION/DRUG HISTORY
Has the patient ever undergone muscle, nerve, or spinal cord injections to reduce spasticity? (For example, Botox, Phenol, Baclofen Pump)  ☐ Yes  ☐ No
If yes, on how many different occasions?________________________________
Name(s) of drug(s) used:____________________________________________
What area(s)/muscle(s) were injected?_________________________________
Date of last injections?______________________________________________

Has the patient ever taken oral medications to reduce/control spasticity? (For example, Baclofen)  ☐ Yes  ☐ No
If yes, name(s) of drug(s):____________________________________________

Does the patient regularly take other oral medications?  ☐ Yes  ☐ No
If yes, name(s) of drug(s):____________________________________________

THERAPY HISTORY
Does the patient currently receive physical therapy?  ☐ Yes  ☐ No
If yes, how often? In what setting?_____________________________________
Briefly explain how therapy time is primarily spent: ________________________

Has the patient participated in alternative therapies such as hippotherapy or night time electrical stimulation (TES)?  ☐ Yes  ☐ No
If yes, please describe: ______________________________________________
EQUIPMENT HISTORY
Does the patient regularly utilize any assistive devices or adaptive equipment such as a walker, canes, crutches, wheelchair, power scooter, or stander? □ Yes □ No
If yes, please list all equipment and where it is used: __________________________
________________________________________________________________________

Does the patient regularly wear braces or orthotics such as AFOs, shoe inserts, arch supports, or a lift? □ Yes □ No
If yes, what kind? __________________________________________________________
How much time are they worn? _____________________________________________
Date the most current braces were received: _________________________________

TRIP/FALL HISTORY
Does patient trip/stumble on a regular basis when walking? □ Yes □ No
When running? □ Yes □ No □ Not able to run
If yes, how often on average? ____ times per day / week / hour
How often does the patient fall? ____ times per day / week / hour
Is there a pattern to these trips/falls? □ Yes □ No □ Uncertain
If yes, describe how/when/where/why they occur: ____________________________
________________________________________________________________________

ENDURANCE HISTORY
Does patient fatigue more easily than peers/family members when walking? □ Yes □ No
If yes, how long can the patient walk before needing to rest? (time or distance)
________________________________________________________________________

PAIN HISTORY
Does the patient experience or complain of pain during or after long periods of standing or walking? □ Yes □ No
If yes, where specifically does the pain occur? (side of body, area affected)
________________________________________________________________________
How often? ____________________________ How severe? (0-10) __________
How is the pain treated? (medicine, rest, ice, heat, massage, etc) ____________
________________________________________________________________________
Does the treatment help? □ Yes □ No
OTHER MEDICAL HISTORY
Patient’s current height: ______________
Patient’s current weight: ______________

Does the patient have a shunt for hydrocephalus? □ Yes □ No
If yes, age it was put in? ______
Number of times revised? ______
Date of last revision? ______

Does the patient have a seizure disorder? □ Yes □ No
If yes, is it controlled? □ Yes □ No
How frequently does the patient have seizures? _____________________________

OTHER PROVIDERS/ SPECIALISTS INVOLVED
Does the patient see any specialists? □ Yes □ No
If yes, please list names and the specialty area: ______________________________
______________________________________________________________________

PATIENT/ FAMILY GOALS & CONCERNS
What are the major concerns with how the patient walks? _________________

What stands out, bothers, or limits the patient the most? ___________________

What would you or the patient most like to see changed if possible? Please be
specific (trip less, falls less, not turn left leg in, make right knee straighter, etc.):
_____________________________________________________________________

Is there anything else that we should know about the patient? (personality,
attention span, etc.)______________________________________________________
______________________________________________________________________

EDUCATIONAL HISTORY
What is the highest grade level equivalent that the patient has completed or is
generally able to perform? Please check one:
□ Not applicable □ 4th □ 10th
□ Pre-school or Daycare □ 5th □ 11th
□ Kindergarten □ 6th □ 12th
□ 1st □ 7th □ College
□ 2nd □ 8th □ Other___
□ 3rd □ 9th
_________