

**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

Date:	Procedure(s):	Facility/Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Not applicable        | <input type="checkbox"/> 4 <sup>th</sup> | <input type="checkbox"/> 10 <sup>th</sup> |
| <input type="checkbox"/> Pre-school or Daycare | <input type="checkbox"/> 5 <sup>th</sup> | <input type="checkbox"/> 11 <sup>th</sup> |
| <input type="checkbox"/> Kindergarten          | <input type="checkbox"/> 6 <sup>th</sup> | <input type="checkbox"/> 12 <sup>th</sup> |
| <input type="checkbox"/> 1 <sup>st</sup>       | <input type="checkbox"/> 7 <sup>th</sup> | <input type="checkbox"/> College          |
| <input type="checkbox"/> 2 <sup>nd</sup>       | <input type="checkbox"/> 8 <sup>th</sup> | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> 3 <sup>rd</sup>       | <input type="checkbox"/> 9 <sup>th</sup> | _____                                     |