Children's HOSPITAL • ST. LOUIS
One Children's Place
Saint Louis, MO 63110
Phone: 314.454.6154
Fax: 314.454.2380

Motion Analysis Center

Dear Parents,

Your child has been scheduled for a repeat Motion Analysis at St. Louis Children's Hospital

What is Motion Analysis?

Motion analysis is a comprehensive computerize evaluation of how your child walks. It is performed and analyzed by a dedicated team in a lab with specialized equipment to capture motion. The analysis includes a physical examination, videotaping, application of reflective markers and muscle activity sensors, and standing and walking trials for specialized cameras and force plates. Markers are applied with a clear tape and sensor sticky pad. A typical gait lab visit takes 3 to 4 hours. Parents are encouraged and welcome to stay with their child.

Arrival and Check-in:

Please check in at the 4th floor Therapy department registration at least 30 minutes before your scheduled appointment. A motion lab staff member will direct you to the Motion Analysis Center. Be sure to ask for validated parking.

What to Bring and Wear:

- Please bring ALL current walking aides: orthotics/braces, crutches, walkers, canes, etc.
- A Questionnaire is available on the stlouischildrens.org website. Please search motion analysis center and click on resources to find. Please bring ALL completed questionnaire.
- Clothing: To capture your child's walking, both legs, top of shoulders, and hip/waist must to be seen. Recommended clothing includes loose fitting shorts with an elastic waist, T-shirt or tank top, sports bra or 2-piece bathing suit. Your child should feel comfortable!
- Optional: Any familiar small toys, books or devices that will make your child comfortable. Cameras are welcomed.

Questions?

Please contact Therapy Services at 314-454-6154.

Thank You. The Motion Analysis Lab Staff

Todays Date:

Dear Parent or Guardian,

Thank you for completing this questionnaire!

This questionnaire will help us to better understand your child's general health and any problems related to their bone and muscle conditions. This will also help us determine any changes since your previous gait analysis

Your completion of this questionnaire is completely voluntary and your responses will be held in the strictest confidence.

Please answer every question. Some questions may look like others, but each one is different. Please provide only ONE answer on the outcome questionnaire unless it ask for more than one.

There are no right or wrong answers. If you are not sure how to answer a question, just choose the best answer. You can make comments in the margin or in the comment box on the last page. We do read all your comments, so feel free to make as many as you wish.

This is an electronic version of the questionnaire. This allows you to complete and save the questionnaire on your computer. You can also just print it and circle answers. Once completed, you can choose to bring the questionnaire to the appointment or e-mail the saved copy to the therapist at the Motion Analysis Center (miriam.tiktinsky-rupp@bjc.org). Your e-mail may not be secure, so feel free to bring it with you if that is the case.

Once again, Thank you!

Your Child's Name (printed):_____

Your Child's Birth Date: _____

Your Name (printed): _____

Your Relationship to the Patient: _____

Thank you,

Motion Analysis Lab Staff

If you need to cancel your appointment, please call 314-454-6154.

Children's HOSPITAL • ST. LOUIS
BJC HealthCare

Follow-Up Functional Assessment Questionnaire

Patient Name:

D.O.B:

Motion Analysis Center

Thank you for your assistance. If you need help or have any questions about the lab itself, please contact the staff at the Motion Analysis Center at 314-454-0451. To cancel appointment, please call 314-454-6154.

General Information:

1. **Patient's Name:** _____ **Date Of Birth**:_____
   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 any additional 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?** ○ Learning ○ Behavior ○ Both ○ None
   2a. If yes, is medication used for learning or behavior issues? ○ Learning ○ Behavior ○ Both ○ None
   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): _____

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

5. **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.

Follow-Up Functional Assessment Questionnaire

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

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)	○	○	○	○	○
Weakness	○	○	○	○	○
Endurance, tolerance, or strength	○	○	○	○	○
Mental ability (such as lack of concentration or awareness)	○	○	○	○	○
Safety concerns	○	○	○	○	○
Balance	○	○	○	○	○
Other	○	○	○	○	○

Please describe: _____

Follow-Up Functional Assessment Questionnaire

Patient Name:

D.O.B:

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	☐	☐	☐	☐	☐	☐
Hips ○ R ○ L ○ B	☐	☐	☐	☐	☐	☐
Knees ○ R ○ L ○ B	☐	☐	☐	☐	☐	☐
Ankles ○ R ○ L ○ B	☐	☐	☐	☐	☐	☐
Feet ○ R ○ L ○ B	☐	☐	☐	☐	☐	☐
Other :	☐	☐	☐	☐	☐	☐

- **On a Scale of 0 to 10** with 0 being no pain and 10 being the worse pain, where would your rate you child's pain? **/10**
- **Please describe pain:** _____

Surgical or ConservativeTreatment Outcome:

Since your last Gait analysis, did your child have any of the following treatments: check all that apply

- ☐ **Surgery (please explain):** _____
  _____
- ☐ **Botox** (Location: _____)
- ☐ **Medication Changes**
- ☐ **Brace Adjustment or Changes**
- ☐ **Physical Therapy**
- ☐ **None**
- ☐ **Other** (please describe): _____

Please let us know how things have changed with either surgery or any conservative treatments like physical therapy, botox, etc. **Please skip if you did not have any type of treatments or therapies.**

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

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

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

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

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

_____

_____

_____

_____

DO.B:

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

For Parents or Adult Patients who's child/self had surgery please 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 who's child had surgery please answer 7

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

For patient who had surgery answer 8

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. ○

Follow-Up Functional Assessment Questionnaire

Physical Therapy/Community Activities

7. **Is the patient currently involved in a physical therapy program?** ○ Yes ○ No
   If yes, please answer the following questions.
   A. Which of the following describes the type of physical therapy program? Check all that apply.
   - ☐ 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. 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:

     _____

8. **Is your child involved in any other community based therapies or programs? check all that apply**
   - ☐ a. Occupational therapy
   - ☐ b. Speech therapy
   - ☐ c. Recreational/Competitive Sports
   - ☐ d. Dance classes
   - ☐ e. Music Classes
   - ☐ f. Art Classes
   - ☐ h. Religious Groups
   - ☒ j. Behavioral groups or counseling
   - ☐ k. School Clubs or groups

   ☐ Other (please describe):

   _____
   _____
   _____
   _____
   _____

If there is anything else you would like to share with us, please let us know here.

_____
_____
_____
_____
_____

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

Patient's Name:_____ **D.O.B:** _____

Relationship to Child: _____

Date of Completion (dd/mm/yyyy): _____ / _____ /_____

Completed by Research Team

REB #: _____ **Study ID:** _____

Event: ❍ Baseline ❍ Post-Op Month #: _____

Gait Outcomes Assessment List (GOAL™) Questionnaire

Parent Version

1. We want to know about your child's walking and mobility.
2. Please answer <u>all</u> questions by circling OR clicking on the button the number that fits best.
3. You may choose to add more items that are important to you at the end of the questionnaire.

For example:

A) Activities of Daily Living & Independence								**LEVEL OF ASSISTANCE**				**IS THIS <u>YOUR GOAL</u> TO IMPROVE?**		
Consider how your child **<u>usually</u>** performs each of the following activities. 1) Rate how **easy or difficult** it was for your child to perform each of these activities in the **<u>past 4 weeks</u>**; **AND** 2) Choose how much **assistance** your child required to help them perform these activities; **AND** 3) Select **how important a goal** it is for you to have your child improve in each of the following activities.														
During the <u>past 4 weeks</u>:	***Extremely Difficult / Impossible***	***Very Difficult***	***Difficult***	***Slightly Difficult***	***Easy***	***Very Easy***	***No problem at all***	**TOTAL**	**MODERATE**	**MINIMAL / SUPERVISED**	**INDEPENDENT**	**NOT A GOAL**	**SOMEWHAT IMPORTANT**	**VERY IMPORTANT**
1. Getting in and out of bed	0 ○	1 ○	2 ○	3 ○	4 ○	5 ◉	6 ○	○ 0	◉ 1	○ 2	○ 3	○ 0	○ 1	◉ 2

In the above example, **getting in and out of bed** was rated as ***very easy;***
required a ***moderate level of assistance;*** and improving this was a ***very important*** goal.

A) Activities of Daily Living & Independence

Consider how your child **usually** performs each of the following activities.
1) Rate how **easy or difficult** it was for your child to perform each of these activities in the **past 4 weeks**; **AND**
2) Choose how much **assistance** your child required to help them perform these activities; **AND**
3) Select **how important a goal** it is for you to have your child **improve** in each of the following activities.

During the past 4 weeks:	*Extremely Difficult / Impossible*	*Very Difficult*	*Difficult*	*Slightly Difficult*	*Easy*	*Very Easy*	*No problem at all*	LEVEL of ASSISTANCE: TOTAL	MODERATE	MINIMAL / SUPERVISED	INDEPENDENT	IS THIS YOUR GOAL TO IMPROVE?: NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
1. Getting in and out of bed	0	1	2	3	4	5	6	0	1	2	3	0	1	2
2. Getting in and out of a chair (or wheelchair)	0	1	2	3	4	5	6	0	1	2	3	0	1	2
3. Standing at a sink or counter	0	1	2	3	4	5	6	0	1	2	3	0	1	2
4. Washing/bathing his/her self (eg. shower or tub)	0	1	2	3	4	5	6	0	1	2	3	0	1	2
5. Getting dressed	0	1	2	3	4	5	6	0	1	2	3	0	1	2
6. Carrying an object while walking (eg. toy, book, cell or mobile phone)	0	1	2	3	4	5	6	0	1	2	3	0	1	2
7. Opening a door	0	1	2	3	4	5	6	0	1	2	3	0	1	2
8. Picking up an object off the floor	0	1	2	3	4	5	6	0	1	2	3	0	1	2
9. Getting in and out of a vehicle (eg. car, van or bus)	0	1	2	3	4	5	6	0	1	2	3	0	1	2
A1. Other activity: _____	0	1	2	3	4	5	6	0	1	2	3	0	1	2

B) Gait Function & Mobility

Consider how your child **usually** performs each of the following activities.

1) Rate how **easy or difficult** it was for your child to perform each of these activities in the **past 4 weeks**; **AND**
2) Choose what **walking aid** your child required to help them perform these activities; **AND**
3) Select **how important a goal** it is for you to have your child **improve** in each of the following activities.

During the past 4 weeks:	*Extremely Difficult / Impossible*	*Very Difficult*	*Difficult*	*Slightly Difficult*	*Easy*	*Very Easy*	*No problem at all*	WALKING AID REQUIRED: WHEELCHAIR	WALKER	TWO CANES / CRUTCHES	ONE CANE / CRUTCH / HAND SUPPORT, RAILING OR WALL	INDEPENDENT	IS THIS YOUR GOAL TO IMPROVE? NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
10. Walking for more than 250 meters (about 2 blocks or 2 football fields)	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
11. Getting around at school (indoors)	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
12. Getting around at home	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
13. Walking for more than 15 minutes	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
14. Walking faster than usual (eg. to keep up with others)	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
15. Stepping around or avoiding obstacles	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
16. Going up and down stairs	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
17. Going up and down slopes	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
18. Walking on uneven ground (rough, rocky, sandy)	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
19. Walking on slippery surfaces (wet or icy)	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○

C) Pain, Discomfort & Fatigue

Consider each of the following items.

1) Rate how **often** your child experienced pain or discomfort or tiredness in the **past 4 weeks**; **AND**
2) Choose how **severe** the pain or discomfort was; **AND**
3) Select **how important a goal** it is for you to **reduce** your child's pain or discomfort or tiredness in each of the following.

During the past 4 weeks:	*Every Day*	*Very Often (nearly every day)*	*Fairly Often (2 to 3 times a week)*	*A Few Times (once a week)*	*Once or Twice*	*None of the Time*	INTENSITY: SEVERE	INTENSITY: MODERATE	INTENSITY: MILD	INTENSITY: NONE	IS THIS YOUR GOAL TO IMPROVE?: NOT A GOAL	IS THIS YOUR GOAL TO IMPROVE?: SOMEWHAT IMPORTANT	IS THIS YOUR GOAL TO IMPROVE?: VERY IMPORTANT
20. Pain or discomfort in the feet or ankles	0	1	2	3	4	5	0	1	2	3	0	1	2
21. Pain or discomfort in the lower legs (eg. calf or shin)	0	1	2	3	4	5	0	1	2	3	0	1	2
22. Pain or discomfort in the knees	0	1	2	3	4	5	0	1	2	3	0	1	2
23. Pain or discomfort in the thighs or hips	0	1	2	3	4	5	0	1	2	3	0	1	2
24. Pain or discomfort in the back	0	1	2	3	4	5	0	1	2	3	0	1	2
25. Feeling tired while walking	0	1	2	3	4	5	0	1	2	3	0	1	2
26. Feeling tired during any other physical activities that he/she usually enjoys (eg. swimming, running, horseback riding or other sport)	0	1	2	3	4	5	0	1	2	3	0	1	2
C1. Other pain: _____	0	1	2	3	4	5	0	1	2	3	0	1	2

D) Physical Activities, Sports & Recreation

Consider how your child **usually** performs each of the following activities.

1) Rate how **easy or difficult** it was for your child to typically perform each of these activities in the **past year**; **AND**
2) Select **how important a goal** it is for you to have your child **improve** in each of the following activities.

During the past year:	*Extremely Difficult / Impossible*	*Very Difficult*	*Difficult*	*Slightly Difficult*	*Easy*	*Very Easy*	*No problem at all*	My child did not have the chance to do this activity in the past year	IS THIS YOUR GOAL TO IMPROVE? NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
27. Running	0	1	2	3	4	5	6	☐	0	1	2
28. Participating in gliding sports (eg. skating, rollerblading, skiing, skate/snowboarding)	0	1	2	3	4	5	6	☐	0	1	2
29. Riding a bike or tricycle (with or without training wheels)	0	1	2	3	4	5	6	☐	0	1	2
30. Swimming	0	1	2	3	4	5	6	☐	0	1	2
31. Participating in sports that require running (eg. soccer, baseball, football, track)	0	1	2	3	4	5	6	☐	0	1	2
32. Participating in sports that require jumping (eg. basketball, volleyball)	0	1	2	3	4	5	6	☐	0	1	2
33. Participating in activities that require balance (eg. dance, gymnastics, martial arts)	0	1	2	3	4	5	6	☐	0	1	2
34. Climbing (eg. ladder or playground equipment)	0	1	2	3	4	5	6	☐	0	1	2
D1. Other recreational or sporting activity: _____	0	1	2	3	4	5	6		0	1	2

E) Gait Pattern & Appearance

Consider how your child **usually** walks.

1) Rate how **much of a problem** your child experienced with each of the following in the **past 4 weeks**; **AND**
2) Select **how important a goal** it is for you to have your child **improve** in each of the following.

During the past 4 weeks:	*Extremely Difficult / Impossible*	*Very Difficult*	*Difficult*	*Slightly Difficult*	*Easy*	*Very Easy*	*No problem at all*	IS THIS YOUR GOAL TO IMPROVE? NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
35. Walking with his/her feet flat on the ground	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○
36. Walking taller or more upright (less crouched or bent at the knees)	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○
37. Walking with his/her feet pointing straight ahead	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○
38. Walking without dragging his/her feet	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○
39. Walking without tripping and falling	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○
40. Wearing footwear of his/her choice (eg. shoes, boots, sandals)	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○
E1. Other aspect of your child's walking: _____	0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	0 ○	1 ○	2 ○

F) Use of Braces & Mobility Aids

Consider each of the following items.
1) Rate how **your child feels** about using each of the following in the **past 4 weeks**; **AND**
2) Select **how important a goal** it is for you to have your child to **reduce or eliminate their use of these devices.**

During the past 4 weeks:	*Very Unhappy*	*Unhappy*	*Neither Happy nor Unhappy*	*Happy*	*Very Happy*	IS THIS YOUR GOAL TO REDUCE USE / ELIMINATE? NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
41. Wearing braces or orthotics (eg. AFO)	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
42. Using a walking aid (eg. walker, stick, cane, crutches)	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
43. Using a wheelchair	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○

☐	My child has not been prescribed to use braces, lifts or orthotics.
☐	My child chooses not to use his/her prescribed braces, lifts or orthotics.
☐	My child does not use any walking aids.
☐	My child does not use a wheelchair.

G) Body Image & Self-Esteem

Consider each of the following items.
1) Rate how **your child feels** about each of the following in the **past 4 weeks**; **AND**
2) Select **how important a goal** it is for you to have your child **improve** in each of the following.

During the past 4 weeks:	*Very Unhappy*	*Unhappy*	*Neither Happy nor Unhappy*	*Happy*	*Very Happy*	IS THIS YOUR GOAL TO IMPROVE? NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
44. The shape and position of his/her legs	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
45. The shape and position of his/her feet	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
46. The symmetry of his/her legs (in length and size)	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
47. The way he/she gets around compared with others	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
48. The way others feel about how he/she gets around	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○
49. How he/she is treated by others	0 ○	1 ○	2 ○	3 ○	4 ○	0 ○	1 ○	2 ○

Other Goals	IS THIS YOUR GOAL TO IMPROVE?		
If there are any other goals (long or short term) that we have missed, please list them below **AND** Select **how important a goal** it is for you to have your child **improve** in each.	NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
Other Goals:			
1.	0	1	2
2.	0	1	2
3.	0	1	2
4.	0	1	2
5.	0	1	2

Comments & Suggestions

THANK YOU FOR YOUR PARTICIPATION!