Patient Reported Medical History

Record ID ______________________

Please tell us when this form will be filled out within the continuum of care, e.g., admission, pre-op, annual visit, etc. ______________________

Physical Therapy in Last Four Months

	Group	Individual	None
School-Based	☐	☐	☐
Outpatient Center or Clinic-Based	☐	☐	☐

Home-Based Physical Therapy in Last Four Months? ◯ Yes ◯ No

Inpatient-Based Physical Therapy in Last Four Months ◯ Yes ◯ No

School-Based - Group - Frequency
◯ 1/week
◯ 2/month
◯ 1/month
◯ Less than 1/month
◯ Don't know

School-Based - Individual - Frequency
◯ 1/week
◯ 2/month
◯ 1/month
◯ Less than 1/month
◯ Don't know

Outpatient Center or Clinic Based - Group - Frequency
◯ 4-5/week
◯ 2-3/week
◯ 1/week
◯ 2/month
◯ 1/month
◯ Less than 1/month
◯ Yearly
◯ Don't know

Outpatient Center or Clinic Based - Individual - Frequency
◯ 4-5/week
◯ 2-3/week
◯ 1/week
◯ 2/month
◯ 1/month
◯ Less than 1/month
◯ Yearly
◯ Don't know

Home - Frequency
◯ 4-5/week
◯ 2-3/week
◯ 1/week
◯ 2/month
◯ 1/month
◯ Less than 1/month
◯ Yearly
◯ Don't know

School-Based - Group - Minutes per Session
- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ Don't know

School-Based - Individual - Minutes per Session
- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ Don't know

Outpatient Center or Clinic-Based - Group - Minutes per Session
- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ 90-120
- ◯ 120-160
- ◯ 160-180
- ◯ Don't Know

Outpatient Center or Clinic-Based - Individual - Minutes per Session
- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ 90-120
- ◯ 120-160
- ◯ 160-180
- ◯ Don't Know

Home - Minutes per Session
- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ Don't know

Inpatient - Minutes per Day
- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ 90-120
- ◯ Don't know

Occupational Therapy in Last Four Months

	Group	Individual	None
School-Based	☐	☐	☐
Outpatient Center or Clinic-Based	☐	☐	☐

Home-Based Occupational Therapy in Last Four Months? ◯ Yes ◯ No

Inpatient-Based Occupational Therapy in Last Four Months? ◯ Yes ◯ No

School-Based - Group - Frequency
- ◯ 1/wk
- ◯ 2/month
- ◯ 1/month
- ◯ Less than 1/month
- ◯ Don't know

School-Based - Individual - Frequency
- ◯ 1/wk
- ◯ 2/month
- ◯ 1/month
- ◯ Less than 1/month
- ◯ Don't know

Outpatient Center or Clinic-Based - Group - Frequency

- ◯ 4-5/wk
- ◯ 2-3/wk
- ◯ 1/wk
- ◯ 2/month
- ◯ 1/month
- ◯ Less than 1/month
- ◯ Yearly
- ◯ Don't know

Outpatient Center or Clinic-Based - Individual - Frequency

- ◯ 4-5/wk
- ◯ 2-3/wk
- ◯ 1/wk
- ◯ 2/month
- ◯ 1/month
- ◯ Less than 1/month
- ◯ Yearly
- ◯ Don't know

Home - Frequency

- ◯ 4-5/wk
- ◯ 2-3/wk
- ◯ 1/wk
- ◯ 2/month
- ◯ 1/month
- ◯ Less than 1/month
- ◯ Yearly
- ◯ Don't know

School-Based - Group - Minutes per Session

- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ Don't know

School-Based - Individual - Minutes per Session

- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ Don't know

Outpatient Center or Clinic-Based - Group - Minutes per Session

- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ 90-120
- ◯ 120-160
- ◯ 160-180
- ◯ Don't Know

Outpatient Center or Clinic-Based - Individual - Minutes per Session

- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ 90-120
- ◯ 120-160
- ◯ 160-180
- ◯ Don't Know

Home - Minutes per Session

- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ Don't know

Inpatient - Minutes per Day

- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ 90-120
- ◯ Don't know

Speech Therapy in Last Four Months

	Group	Individual	None
School-Based	☐	☐	☐
Outpatient Center or Clinic-Based	☐	☐	☐

Home-Based Speech Therapy in Last Four Months? ◯ Yes ◯ No

Inpatient-Based Speech Therapy in Last Four Months? ◯ Yes ◯ No

School-Based - Group - Frequency
◯ 1/wk
◯ 2/month
◯ 1/month
◯ Less than 1/month
◯ Don't know

School-Based - Individual - Frequency
◯ 1/wk
◯ 2/month
◯ 1/month
◯ Less than 1/month
◯ Don't know

Outpatient Center or Clinic-Based - Group - Frequency
◯ 4-5/wk
◯ 2-3/wk
◯ 1/wk
◯ 2/month
◯ 1/month
◯ Less than 1/month
◯ Yearly
◯ Don't know

Outpatient Center or Clinic-Based - Individual - Frequency
◯ 4-5/wk
◯ 2-3/wk
◯ 1/wk
◯ 2/month
◯ 1/month
◯ Less than 1/month
◯ Yearly
◯ Don't know

Home - Frequency
◯ 4-5/wk
◯ 2-3/wk
◯ 1/wk
◯ 2/month
◯ 1/month
◯ Less than 1/month
◯ Yearly
◯ Don't know

School-Based - Group - Minutes per Session
◯ 0-30
◯ 30-60
◯ 60-90
◯ Don't know

School-Based - Individual - Minutes per Session
◯ 0-30
◯ 30-60
◯ 60-90
◯ Don't know

Outpatient Center or Clinic-Based - Group - Minutes per Session
- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ 90-120
- ◯ 120-160
- ◯ 160-180
- ◯ Don't Know

Outpatient Center or Clinic-Based - Individual - Minutes per Session
- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ 90-120
- ◯ 120-160
- ◯ 160-180
- ◯ Don't Know

Home - Minutes per Session
- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ Don't know

Inpatient - Minutes per Day
- ◯ 0-30
- ◯ 30-60
- ◯ 60-90
- ◯ 90-120
- ◯ Don't know

Vision Services in Last Four Months

Vision Services in Last Four Months
- ◯ Yes
- ◯ No

Vision Services - Frequency
- ◯ 4-5/wk
- ◯ 2-3/wk
- ◯ 1/wk
- ◯ 2/month
- ◯ 1/month
- ◯ Less than 1/month
- ◯ Yearly
- ◯ Don't know

Vision Services - Delivered By
- ◯ Developmental Optometrist
- ◯ Occupational Therapist
- ◯ Other
- ◯ Don't Know

Serial Castings in Last Four Months

Serial Castings in Last Four Months
- ◯ Yes
- ◯ No

Serial Castings - Limbs
- ☐ Arms
- ☐ Legs
- ☐ Combined with Botox

Intensive Therapy Program

Child Participated in Intensive Therapy Program (2 or more times per week over several weeks)
- ◯ Yes
- ◯ No

Intensive Therapy Type
- ☐ Constraint Induced / Forced Use
- ☐ Treadmill Training
- ☐ Strengthening
- ☐ Other

Intensive Therapy Type - Other ______________________________

Orthopedic or Neurosurgery Since Last Visit

Orthopedic or Neurosurgery Since Last Visit
- ◯ Yes
- ◯ No

Physical or Occupational Therapist Evaluated Child Before Surgery and Made Recommendations for Seating and Equipment that Would be Needed Post-Surgery
- ◯ Yes
- ◯ No

Child Received an Increase in Physical and/or Occupational Therapy Services Since Surgery
- ◯ Yes
- ◯ No

Increase in Physical/Occupational Therapy
- ☐ Physical
- ☐ Occupational

Location
- ☐ Inpatient
- ☐ Home
- ☐ Outpatient Clinic
- ☐ School

Child Participated in Inpatient Rehabilitation Program After Surgery
- ◯ Yes
- ◯ No

Days Child Was an Inpatient
- ◯ 7 Days or Less
- ◯ 8-14 Days
- ◯ 15-21 Days
- ◯ Greater than 21 Days

Daily Activities Difficulty

Upper Body Dressing Difficulty
- ◯ Not Possible (Almost Impossible)
- ◯ Very Difficult
- ◯ Difficult
- ◯ Slightly Difficult
- ◯ Easy
- ◯ Very easy
- ◯ No Problem At All

Lower Body Dressing Difficulty
- ◯ Not Possible (Almost Impossible)
- ◯ Very Difficult
- ◯ Difficult
- ◯ Slightly Difficult
- ◯ Easy
- ◯ Very easy
- ◯ No Problem At All

Grooming Difficulty

- ◯ Not Possible (Almost Impossible)
- ◯ Very Difficult
- ◯ Difficult
- ◯ Slightly Difficult
- ◯ Easy
- ◯ Very easy
- ◯ No Problem At All

Feeding Difficulty

- ◯ Not Possible (Almost Impossible)
- ◯ Very Difficult
- ◯ Difficult
- ◯ Slightly Difficult
- ◯ Easy
- ◯ Very easy
- ◯ No Problem At All

Mobile Equipment

	Child Has	Child Uses	Neither
Walker (hand-held, no extra support for trunk or pelvis)	☐	☐	☐
Gait-trainer/walker (with extra supports for trunk or pelvis)	☐	☐	☐
Bilateral Canes	☐	☐	☐
Bilateral Crutches	☐	☐	☐
Unilateral Canes	☐	☐	☐
Unilateral Crutches	☐	☐	☐
Manual Wheelchair	☐	☐	☐
Power Wheelchair	☐	☐	☐
Hoyer Lift	☐	☐	☐
Stander	☐	☐	☐
Adapted Bike/Toy Car	☐	☐	☐

Device - Location of Use

	Home	School	Community	During therapy
Walker (hand-held, no extra support for trunk or pelvis)	☐	☐	☐	☐
Gait-trainer/walker with extra supports for trunk or pelvis	☐	☐	☐	☐
Bilateral canes	☐	☐	☐	☐
Bilateral crutches	☐	☐	☐	☐
Unilateral canes	☐	☐	☐	☐
Unilateral crutches	☐	☐	☐	☐
Manual wheelchair	☐	☐	☐	☐

Power wheelchair	☐	☐	☐	☐
Hoyer Lift	☐	☐	☐	☐
Stander	☐	☐	☐	☐
Adapted bike/toy car	☐	☐	☐	☐

Device - Percent Time of Use

Mobile Device - Percent of Time - Walker (hand-held, no extra support for trunk or pelvis)
- ◯ 100
- ◯ 75
- ◯ 50
- ◯ 25 or less

Mobile Device - Percent of Time - Gait-trainer/walker with extra supports for trunk or pelvis
- ◯ 100
- ◯ 75
- ◯ 50
- ◯ 25 or less

Mobile Device - Percent of Time - Bilateral Canes
- ◯ 100
- ◯ 75
- ◯ 50
- ◯ 25 or less

Mobile Device - Percent of Time - Bilateral Crutches
- ◯ 100
- ◯ 75
- ◯ 50
- ◯ 25 or less

Mobile Device - Percent of Time - Unilateral Canes
- ◯ 100
- ◯ 75
- ◯ 50
- ◯ 25 or less

Mobile Device - Percent of Time - Unilateral Crutches
- ◯ 100
- ◯ 75
- ◯ 50
- ◯ 25 or less

Mobile Device - Percent of Time - Manual Wheelchair
- ◯ 100
- ◯ 75
- ◯ 50
- ◯ 25 or less

Mobile Device - Percent of Time - Power Wheelchair
- ◯ 100
- ◯ 75
- ◯ 50
- ◯ 25 or less

Mobile Device - Percent of Time - Hoyer Lift
- ◯ 100
- ◯ 75
- ◯ 50
- ◯ 25 or less

Mobile Device - Percent of Time - Stander
- ◯ 100
- ◯ 75
- ◯ 50
- ◯ 25 or less

Mobile Device - Percent of Time - Adapted Bike/Toy Car

◯ 100
◯ 75
◯ 50
◯ 25 or less

Communication Devices

	Child Has	Child Uses	Neither
Non-Electronic Communication Device	☐	☐	☐
Electronic Communication Device	☐	☐	☐

Communication Device - Location of Use

	Home	School	Community	During therapy
Non-electronic Communication Device	☐	☐	☐	☐
Electronic Communication Device	☐	☐	☐	☐

Communication Device - Percent of Time Use - Non-electronic Communication Device

◯ 100
◯ 75
◯ 50
◯ 25 or less

Communication Device - Percent of Time Use - Electronic Communication Device

◯ 100
◯ 75
◯ 50
◯ 25 or less

Aids/Other Assistive Equipment

	Child Has	Child Uses	Neither
Feeding	☐	☐	☐
Bathing	☐	☐	☐
Toileting	☐	☐	☐
Dressing	☐	☐	☐
Vision Intervention	☐	☐	☐
Written Communication/Materials Manipulation	☐	☐	☐
Hoyer Lift/Other Lift System	☐	☐	☐

Aids/Other Assistive Equipment - Location of Use

	Home	School	Community	During therapy
Feeding	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Vision Intervention	☐	☐	☐	☐
Written Communication/Materials Manipulation	☐	☐	☐	☐
Hoyer Lift/Other Lift System	☐	☐	☐	☐

Aids/Other Assistive Equipment - Percent of Time Use - Feeding

○ 100
○ 75
○ 50
○ 25 or less

Aids/Other Assistive Equipment - Percent of Time Use - Bathing

○ 100
○ 75
○ 50
○ 25 or less

Aids/Other Assistive Equipment - Percent of Time Use - Toileting

○ 100
○ 75
○ 50
○ 25 or less

Aids/Other Assistive Equipment - Percent of Time Use - Dressing

○ 100
○ 75
○ 50
○ 25 or less

Aids/Other Assistive Equipment - Percent of Time Use - Vision Intervention

○ 100
○ 75
○ 50
○ 25 or less

Aids/Other Assistive Equipment - Percent of Time Use - Written Communication/Materials Manipulation

○ 100
○ 75
○ 50
○ 25 or less

Aids/Other Assistive Equipment - Percent of Time Use - Hoyer Lift/Other Lift System

○ 100
○ 75
○ 50
○ 25 or less

Thoraco-Lumbo-Sacral Orthosis (TLSO)

	Child Has	Child Uses	Neither
Thoraco-Lumbo-Sacral Orthosis (TLSO)	☐	☐	☐

Type
- ◯ Soft
- ◯ Hard

Frequency of Use
- ◯ All day and night
- ◯ All night only
- ◯ All day only
- ◯ All day only
- ◯ Day only when upright

Abduction Wedge

	Child Has	Child Uses	Neither
Abduction Wedge	☐	☐	☐

Frequency of Use
- ◯ All day and night
- ◯ All night only
- ◯ Only in chair

Orthotic Devices

	Child Has	Child Uses	Neither
Knee	☐	☐	☐
Ankle	☐	☐	☐
Elbow	☐	☐	☐
Wrist	☐	☐	☐
Finger	☐	☐	☐
Hip	☐	☐	☐

Orthotic Device Use - Time of Day

	Daytime	Nighttime
Knee	☐	☐
Ankle	☐	☐
Elbow	☐	☐
Wrist	☐	☐
Finger	☐	☐
Hip	☐	☐

Orthotic Device Use - Frequency - Knee
- ◯ Every day
- ◯ 3-5 days/wk
- ◯ 2-3 days/wk
- ◯ 1 day/wk
- ◯ Less than 1 day/wk

Orthotic Device Use - Frequency - Ankle: Day
- ◯ At Least 6-8 Hrs Every Day
- ◯ Less than 6 Hrs Every Day
- ◯ 3-5 Days/wk
- ◯ Less than 3 Days/wk

Orthotic Device Use - Frequency - Ankle: Nighttime
- ◯ All Night Every Night
- ◯ A Few Hours Every Night
- ◯ All Night, 3-5 Nights /wk
- ◯ All Night, Less than 3 Nights /wk
- ◯ A Few Hours Each Night, Less than 3 Nights /wk

Orthotic Device Use - Frequency - Elbow
- ◯ Occassionally
- ◯ 1x/wk
- ◯ 2-3x/wk
- ◯ More than 3x/wk

Orthotic Device Use - Frequency - Wrist
- ◯ Occassionally
- ◯ 1x/wk
- ◯ 2-3x/wk
- ◯ More than 3x/wk

Orthotic Device Use - Frequency - Finger
- ◯ Occassionally
- ◯ 1x/wk
- ◯ 2-3x/wk
- ◯ More than 3x/wk

Orthotic Device Use - Frequency - Hip
- ◯ Occassionally
- ◯ 1x/wk
- ◯ 2-3x/wk
- ◯ More than 3x/wk

Physical and Recreational Activities

Does child participate in activities that increase heart rate and makes them sweat?
- ◯ Yes
- ◯ No

Frequency of Activities
- ◯ Occasionally
- ◯ 1/wk
- ◯ 2-3/wk
- ◯ More than 3/wk

Does child participate in recreational strengthening activities?
- ◯ Yes
- ◯ No

Frequency of Activities
- ◯ Occasionally
- ◯ 1/wk
- ◯ 2-3/wk
- ◯ More than 3/wk

Is child physically active with at least 60 minutes with increased heart rate?
- ◯ Yes
- ◯ No

Frequency of Activities

- ◯ Occasionally
- ◯ 1/wk
- ◯ 2-3/wk
- ◯ More than 3/wk

Recreational Activities in Which Child Participates

- ☐ Group sports
- ☐ Individual sports
- ☐ Recreational sports
- ☐ Outdoor activities
- ☐ Playground activities
- ☐ Calisthenics/general exercise
- ☐ Strengthening
- ☐ Other
- ☐ No Recreational Activities

Recreational Activities - Other ______________________________

Specific Activities

- ☐ Dance
- ☐ Martial arts
- ☐ Swimming
- ☐ Therapeutic horseback riding
- ☐ Biking
- ☐ Soccer
- ☐ Baseball
- ☐ Basketball
- ☐ Yoga
- ☐ Sled Hockey
- ☐ Cheerleading
- ☐ Boxing
- ☐ Other

Specific Activities - Other ______________________________

Other Programs or Activities Due to Child's CP

- ◯ Yes
- ◯ No

List Other Programs or Activities

____