Orthopædic Institute for Children
IN ALLIANCE WITH UCLA Health

Intake Form: Initial Visit, Center for Cerebral Palsy

Patient Name:_____DOB: _____

Gender:_____Name of Individual Completing Form: _____

Relationship To Patient: _____

Who lives in the same house as your child?: _____

For what concern was your child referred to the clinic (problem with walking/sitting, feeding problems, therapeutic needs/equipment needs, problem with hands/arms):

_____

_____

Physical Function

Please list the assistive devices that your child currently uses (walker, cane, manual wheelchair, motorized wheelchair, stander):

_____

Please list the braces that your child currently wears (AFO, KAFO, in-shoe inserts):

_____

Please use the scale below (1-6):

What describes your child's walking ability to get around the house?
1 2 3 4 5 6

What describes your child's walking ability to walk between classrooms?
1 2 3 4 5 6

What describes your child's walking ability to walk in a mall?
1 2 3 4 5 6

Rating 1

Uses wheelchair: May stand for transfers, may do some stepping supported by another person or using a walker/frame.

Rating 2

Uses walker or frame: Without help from another person.

Rating 3

Uses crutches: Without help from another person.

Rating 4

Uses stickes (one or two): Without help from another person.

Rating 5

Independent on level surfaces: Does not use walking aids or need help from another person.* Requires a rail for stairs.

*If uses furniture, walls, fences, shot fronts forsupport, please use 4 as appropriate description.

Rating 6

Independent on all surface: Does not use any walking aids or need any help from another person when walking over all surfaces including unveven ground, curbs etc. and in a crowded environment.

Intake Form: Initial Visit, Center for Cerebral Palsy

Please choose the best level of function for your child's **right** arm:

1. Can handle objects like a spoon, pencil or ball easily and successfully and does not have any restriction of independence in daily activities.
2. Can handle most objects but is clumsy and/or slow. Certain activities may be avoided so (s)he cannot do some things a normal same age child could do with the arm. The arm may restrict independence in daily activities.
3. Can handle objects only with difficulty; needs help such as putting a pencil into the hand, can do only big movements and with difficulty.
4. Can only handle a limited selection of easily managed objects in adapted situations such as holding down a piece of paper or using the hand as a weight. Performs parts of activities with limited success. Requires continuous support.
5. Does not handle objects and has severely limited ability to perform simple actions. Requires total assistance.

Please choose the best level of function for your child's **left** arm:

1. Can handle objects like a spoon, pencil or ball easily and successfully and does not have any restriction of independence in daily activities.
2. Can handle most objects but is clumsy and/or slow. Certain activities may be avoided so (s)he cannot do some things a normal same age child could do with the arm. The arm may restrict independence in daily activities.
3. Can handle objects only with difficulty; needs help such as putting a pencil into the hand, can do only big movements and with difficulty.
4. Can only handle a limited selection of easily managed objects in adapted situations such as holding down a piece of paper or using the hand as a weight. Performs parts of activities with limited success. Requires continuous support.
5. Does not handle objects and has severely limited ability to perform simple actions. Requires total assistance.

What is your child's current educational environment? (regular age-appropriate schooling, age-appropriate schooling with an aid or accommodations, special education classroom, etc.)

_____

Intake Form: Initial Visit, Center for Cerebral Palsy

What therapies is your child currently receiving? (physical, occupational, speech)

Pregnancy/Birth History

Were there problems during the pregnancy? If so, what?

Was the pregnancy full term? What was the patient's gestational age at birth?

Was there fetal distress present prior to delivery? Please describe.

Was the patient born vaginally or via c-section? Was he/she positioned head or feet downward? Patient's birth weight?

Did the patient spend time in the neonatal intensive care unit after delivery? If so, for how long? Did he/she require a breathing machine, an incubator or a tube for feeding?

Does the child have a twin or triplet? _____

What was your child's birth height? _____

What was your child's head circumference? _____

Intake Form: Initial Visit, Center for Cerebral Palsy

What was the patient's APGAR at 1 and 5 minutes? _____

Were there any traumatic events post-birth? (infections, brain bleeds, etc.) If so, please describe.

_____

_____

Medical History

Does your child have a history of seizures? If so, please describe. (When diagnosed, how often, how controlled)

_____

_____

Does your child have a history of behavioral problems? If so, please describe.

_____

_____

Does your child have a ventricular peritoneal (VP) shunt? If so, at what age was it implanted? Any revision surgeries?

_____

_____

Does your child have a baclofen pump to treat his/her muscle tone? If so, at what age was it implanted?

_____

_____

Does your child have any respiratory difficulties? (asthma, tracheomalacia, bronchomalacia, aspiration, bronchitis, sleep apnea, pneumonia, etc.) If so, what treatments does he/she receive for this?

_____

_____

Intake Form: Initial Visit, Center for Cerebral Palsy

Does your child have a history of weak or soft bones? If so, is he/she receiving any treatment?

Please list any previous broken bones that your child has had along with treatment:

Does your child get his/her nutrition orally or through a gastric-tube/jejunal-tube?

Does your child have any difficulty with bowel or bladder function?

How many times/day does your child urinate? _____

How many times/week does your child have a BM? _____

Is your child toilet trained? _____

Does your child have any heart problems or problems with blood clotting? If so, please describe.

Please list any previous hospitalizations:

Please list any previous surgeries:

Orthopædic Institute for Children

Intake Form: Initial Visit, Center for Cerebral Palsy

Current Medications

_____

_____

Allergies to Medications

_____

_____

Functional History

At what age could your child sit alone? _____

At what age could your child pull to stand and walk along the furniture? _____

At what age could your child roll over? _____

At what age could your child walk without holding on? _____

At what age could your child use a spoon to self-feed? _____

At what age could your child do most of their own self-dressing? _____

At what age was your child toilet-trained? _____

At what age could your child ride a two-wheel bicycle? _____

Which hand does the child use for writing/eating? _____

Orthopædic
Institute for Children

Intake Form: Initial Visit, Center for Cerebral Palsy

Review of Systems

Has your child ever had problems with the following? (circle any/all that apply)

Unexplained weight loss
Fatigue
Vision
Hearing
Ears, Nose, Throat
Lungs/Breathing
Belly pain/GI distress
Urinary symptoms
Heart
Bleeding
Seizures
Abnormal sensation
Skin problems
Depression/Anxiety

*Please explain any circled answers: _____

_____

_____

_____

_____