

Gait Analysis Questionnaire

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Please answer the following questions below as completely as possible. The information that we obtain from this questionnaire will expedite the process while you here.

1. What is your main problem with walking? ( circle all that apply): falls / unbalanced / painful / stiffness / weakness / knees bent / knees too straight / tripping / feet turn in / feet turn out / Feet drag / uncoordinated / legs turn in / trunk leans forward
2. What caused the problem? Premature / birth injury / other: \_\_\_\_\_
3. How long has it been a problem? Less than 6 months / 7-12 months / 1-3 years / more than 5 years / entire life
4. How far can you walk without rest? 1 block / 3-6 blocks / unlimited
5. Have there been any changes in the way you walk since the problem first began? Yes / No  
Within the past year? Yes / No
6. Do you think that you are getting: better / worse / same
7. Please list the physicians & therapists that you have seen and what they have done for you. Include medications, surgeries, interventions (e.g. botox) and therapies, as well as what effect they have had on your walking problem.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Do you have recent x-rays? Yes / No
9. Physical Therapist's name and address: \_\_\_\_\_  
\_\_\_\_\_
10. At what age did you start walking? \_\_\_\_\_



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11. Do you use any of the following: wheelchair / walker / crutches / cane / shoe inserts / braces / twister cables / other: \_\_\_\_\_  
How often are they used: often / occasionally / rarely / never
11. Do you need someone's help to walk? Yes / No
12. Do you ever fall? Never / Daily / Weekly / Monthly
13. What are the most difficult surfaces for you to walk on? \_\_\_\_\_  
\_\_\_\_\_
14. What is the most difficult thing for you to do when walking (stairs, crowds, obstacles, curbs etc.)  
\_\_\_\_\_
15. Do you have any other significant medical problems?  
 \_\_\_ Cognitive impairment: Minimal / moderate / severe  
 \_\_\_ Seizures  
 \_\_\_ Behavior problems or attention deficits (circle)  
 \_\_\_ Hearing impairments  
 \_\_\_ Vision Problems  
 \_\_\_ Obesity  
 \_\_\_ Respiratory problems (asthma, BPD)  
 \_\_\_ Heart problems  
 \_\_\_ Oral Motor Problems (speech, Drooling)  
 \_\_\_ Poor Growth and nutrition  
 \_\_\_ Other: \_\_\_\_\_
16. How does your child climb stairs?  
 Circle one: 2 feet / step    1 foot / step  
 Circle one: needs rail    no rail needed
17. Is there anything else that we should know about you that may help us prepare for and complete this study? \_\_\_\_\_  
\_\_\_\_\_
18. What do you hope to gain from this study? \_\_\_\_\_  
\_\_\_\_\_



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