

Gait Analysis Questionnaire

Name: _____ Age: _____

Primary Care Physician: _____

Orthopedic Surgeon: _____

Rehab Physician: _____

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

1. What is your/ your child's main problem or concern with walking? _____

2. What caused the problem? _____
3. How long has your walking been a problem? _____
4. Have there been any recent changes in the way you/your child walks? _____

5. At what age did you/ your child start walking? _____
6. Have you/ your child had any of the following interventions? By whom? Date? Outcome?
 - a. surgery _____

 - b. injections (Botox, Phenol) _____
 - c. other _____
7. Has your/ your child's endurance increased/ decreased over the past year?
8. Do you/ your child ever fall? _____ How much/ how often? _____
9. How do you/ your child climb stairs? 2 feet/step 1 foot/ step Needs railing No railing needed
10. Do you/your child use any of the following: How much are these used?

_____ wheelchair	_____ cane
_____ walker	_____ shoe inserts
_____ crutches	_____ braces
11. What medications are you/your child taking? _____



12. Do you have any other significant medical problems?

___ Intellectual impairment: Minimal/ Moderate/ Severe

___ Seizures

___ Behavior problems or attentions deficits

___ Heart problems

___ Vision and/or Hearing Problems

___ Poor growth/nutrition

___ Respiratory problems (asthma, BPD)

___ Oral Motor Problems (speech, drooling)

___ Other: _____

13. Who is your/ your child's physical therapist? Address: _____

14. Is there anything else we should know about you/ your child that may help us prepare for and complete this study? _____

15. What do you hope to gain from this consultation? What are your goals? _____

16. Functional Mobility Scale: Please rate the child's walking ability for each of the distances listed below. Please write in the space provided, the number that best describes the child's ability or need for assistance at each of the distances listed.

1 – Uses a wheelchair, stroller or buggy; may stand for transfers and may do some stepping supported by another person or using the walker/frame

2 – Uses K-Walker or other walking frame without help from another person

3 – Uses 2 crutches or 2 sticks without help from another person

4 – Uses 1 crutch or 2 sticks without help from another person

5 – Independent on level surfaces; does not use walking aids or need help from another person. If uses furniture, walls, fences, shop fronts for support, please use 4 as the appropriate description

6 – Independent on all surfaces; does not use any walking aids or need any help from another person when walking, running, climbing and climbing stairs

Walking Distance

Rating 1-6

Walking 5 meters – in a bedroom or other room

Walking 50 meters – at school, in the classroom
and playground

Walking 500 meters – in shopping malls, streets



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