UTHealth Neurosciences
The University of Texas Health Science Center at Houston

New Patient Spasticity Questionnaire

To help us better serve you, please complete this questionnaire and provide any previous medical records prior to your appointment.

Patient Information

Patient Name: ______________________ Date of Birth: __________ Today's Date: __________

Home Phone Number: ______________ Cell Phone Number: ______________ Gender: ☐ Male ☐ Female

Address: ______________________ City: __________ State: ________ Zip Code: ________

Email Address: ____

Emergency Contact: ______________________ Phone Number: ____________________

Care Team

Pediatrician: ______________________ Neurologist: ______________________

Physical Medicine & Rehab Physician: ______________________ Last Seen: __________

Orthopedic Physician: ______________________ Last Seen: __________

Physical Therapist: ______________________ Phone Number: ______________

Occupational Therapist: ______________________ Phone Number: ______________

Speech Therapist: ______________________ Phone Number: ______________

ECI Contact Information: ____

Other MD/Specialty: ____

Other MD/Specialty: ____

Outpatient Therapy Clinic: ____

Home Health Company: ____

Other: ____

Referral Information

Referring Physician: ______________________ Phone Number: ______________

Address: ______________________ City: __________ State: ________ Zip Code: ________

Pregnancy

Select any complications experienced during pregnancy:

- ☐ Preterm labor
- ☐ Placental Abruption
- ☐ Oligohydramnios
- ☐ Fetal Anomalies
- ☐ IUGR
- ☐ None
- ☐ Other:

Born at ________ weeks gestation Birth Weight: __________ Birth Length: __________ FOC: __________

Delivery: ☐ Vaginal ☐ C-Section Anesthesia Given: ☐ Yes ☐ No Reason for C-Section/Anesthesia: ______________

Apgar Scores (if known): 1 minute: __________ 5 minutes: __________ 10 minutes: __________

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Houston, Texas 77030
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UT Physicians
A Part of UTHealth

Condition of Baby at Delivery & in Nursery

Admitted to NICU: ☐ Yes ☐ No Length of stay in NICU: ______________________________

Select any conditions present at delivery:

- ☐ Jaundice
- ☐ Needed Oxygen
  How long? ____________
- ☐ Shunt Placement/Revision
- ☐ ETV
- ☐ Ventilator
- ☐ Seizure Medications
- ☐ Hydrocephalus
- ☐ Hypoxic Ischemic Encephalopathy
- ☐ Congenital Infection
- ☐ Congenital Stroke
- ☐ Brain Malformation
- ☐ Prematurity – Multiple Injuries
- ☐ Prematurity – Intra-ventricular Hemorrhage (Grade: ________)
- ☐ Prematurity – Peri-ventricular Leukomalacia
- ☐ Prematurity – White Matter Injury
- ☐ Genetic Condition:
  ____

Other Problems/Concerns: ______________________________

Age at discharge: ____________________ Results of New Born Screening: ____________________

Medical History

List any conditions for which your child is under the care of a physician: ______________________________

____

Does your child require a tracheostomy? ☐ Yes ☐ No
Does your child require a ventilator? ☐ Yes ☐ No
Has your child been hospitalized in the past 12 months? ☐ Yes ☐ No
Has your child had pneumonia/respiratory infection in the past 12 months? ☐ Yes ☐ No
Does your child have a previous history of cancer or tumors? ☐ Yes ☐ No

If so, please describe the location: ______________________________

Has your child received treatment for a wound in the last two months? ☐ Yes ☐ No

If so, please describe: ______________________________

Age when diagnosed with cerebral palsy (if diagnosed): ________ Type: ☐ Spastic Diplegia ☐ Hemiplegia ☐ Triplegia ☐ Quadriplegia

Has your child received a pneumonia immunization? ☐ Yes ☐ No Date: ____________

Has your child received an influenza immunization? ☐ Yes ☐ No Date: ____________

Are your child's other childhood immunizations up to date? ☐ Yes ☐ No

List all medications, including over the counter medications, herbs, vitamins, etc, that your child is currently taking:

____

____

____

Preferred Pharmacy: ______________________________ Phone Number: ____________

List any food and/or drug allergies your child has and describe what happens if exposed:

____

____

List any family history of medical conditions and the person's relationship to your child:

____

____

Development History

Describe any concerns you may have with general development:

- ☐ Speech: ______________________________
- ☐ Feeding/Swallowing: ______________________________
- ☐ Cognition: ______________________________
- ☐ Hearing: ______________________________
- ☐ Vision: ______________________________

Provide your child's age (in months) when they first performed the following tasks:

Hold head up: ______________ Crawl: ______________ Walk with assistive device: ______________

Roll over: ______________ Stand alone: ______________ Walk alone: ______________

Sit alone without support: ______________

Hand Dominance: ☐ Left handed ☐ Right handed ☐ Ambidextrous

Functional Status

List any adaptive equipment such as a wheelchair, braces, exercise equipment, etc.:

____

____

Does your child use any bathroom equipment? ☐ Yes ☐ No

Is your current equipment meeting all of your child's needs? ☐ Yes ☐ No

Equipment Vendor(s): ______________________________

Describe your child's ability to manage activities such as eating, grooming, dressing, toileting, transfers and walking:

____

____

____

Social History

Do you participate in any support groups/organizations? ☐ Yes ☐ No

If so, please share which groups/organizations: ______________________________

Is the child in school? ☐ Yes ☐ No Name of school: ______________________________

Does your child currently have an IEP or 504 plan? ☐ Yes ☐ No ☐ N/A

If so, which services/accommodations they receive? ______________________________

Is your child employed? ☐ Yes ☐ No

Is your child involved in any sports, recreations or leisure activities? ☐ Yes ☐ No

If so, please list the activities: ______________________________

List who lives in the household: ______________________________

What type of home does the child live in? ☐ 1 story ☐ 2 story

Are there stairs outside or inside the home? ☐ Yes ☐ No

Is it wheelchair accessible? ☐ Yes ☐ No

Is the bathroom accessible to your child? ☐ Yes ☐ No

Is the bedroom accessible to your child? ☐ Yes ☐ No

Can you child work in the kitchen? ☐ Yes ☐ No

What type of transportation is used? ☐ Private ☐ Public

Does anyone in the household smoke? ☐ Yes ☐ No

Does your child receive assistance at home? ☐ Yes ☐ No

If so, what type of assistance? ________________________________ Who is the assistance provided by? __________________________

Imaging (MRI/CT/X-Ray)

Imaging of brain/head: Date: __________________ Discs available? ☐ Yes ☐ No Imaging Facility: ____________________________

Imaging of brain/head: Date: __________________ Discs available? ☐ Yes ☐ No Imaging Facility: ____________________________

Imaging of hips: Date: __________________ Discs available? ☐ Yes ☐ No Imaging Facility: ____________________________

Has your child ever had a bone density scan? ☐ Yes ☐ No Date: __________________ Facility: ____________________________

Surgical History

Provide information on any of the surgeries your child has undergone:

- ☐ Gastrocnemius/heel cord: Date: __________________ Surgeon: _______________________ Hospital: _____________________
- ☐ Adductors: Date: __________________ Surgeon: _______________________ Hospital: _____________________
- ☐ Hamstrings: Date: __________________ Surgeon: _______________________ Hospital: _____________________
- ☐ De-rotation osteotomy: Date: __________________ Surgeon: _______________________ Hospital: _____________________
- ☐ Other: _______________ Date: __________________ Surgeon: _______________________ Hospital: _____________________

Treatments for Spasticity

Does your child currently take Baclofen? ☐ Yes ☐ No

If so, what is the dosage? ____

Has your child received Botox injections for spasticity? ☐ Yes ☐ No

If so, list the muscles or part of body and date injected: ____

List any prior medications taken for spasticity: ____

Bladder Management

Does your child have a bladder routine? ☐ Yes ☐ No

Does your child void on his/her own? ☐ Yes ☐ No

Is/was your child potty trained? ☐ Yes ☐ No At what age? _____________________

Does your child require an intermittent catheterization program? ☐ Yes ☐ No

If so, how many times per day? ____

What volumes do you obtain? ____

Does your child have accidents between catheterizations? ☐ Yes ☐ No

Does your child require other forms of bladder management? ☐ Foley catheter ☐ Suprapubic tube ☐ Continent stoma

Is your child able to feel a full bladder? ☐ Yes ☐ No ☐ I don't know

Does your child experience urinary tract infections? ☐ Yes ☐ No

If so, how many per year? ______

When was their last infection? ______

Which medications were used? ______

Select any procedures your child has undergone:

- ☐ Renal ultrasound: Date: ______ Facility: ______
- ☐ Renal scan: Date: ______ Facility: ______
- ☐ Intravenous pyelogram (IVP): Date: ______ Facility: ______
- ☐ Cystogram: Date: ______ Facility: ______
- ☐ Urodynamic studies: Date: ______ Facility: ______

Bowel Management

Does your child have a bowel routine? ☐ Yes ☐ No

If so, describe the stool consistency, frequency, method of elimination, and time of completion: ______

______

______

Does your child have accidents? ☐ Yes ☐ No

Does your child feel when a suppository is inserted? ☐ Yes ☐ No

Autonomic Dysfunction

Are you familiar with the term Autonomic Dysreflexia (AD)? ☐ Yes ☐ No
Does your child experience goosebumps? ☐ Yes ☐ No
Does your child experience headaches (or head grabbing episodes)? ☐ Yes ☐ No
Does your child experience facial flushing? ☐ Yes ☐ No
Does your child experience tingling? ☐ Yes ☐ No
Does your child experience episodes of high or low blood pressure? ☐ Yes ☐ No
Does your child experience excessive sweating above a certain level of the body? ☐ Yes ☐ No
Does your child experience dizziness? ☐ Yes ☐ No

Pain

Has your child been experiencing pain? ☐ Yes ☐ No

If so, where in the body is the pain? ______

Does the pain seem to "move"? ☐ Yes ☐ No

What seems to either trigger the pain or make it worse? ______

Is there anything that relieves the pain? ______

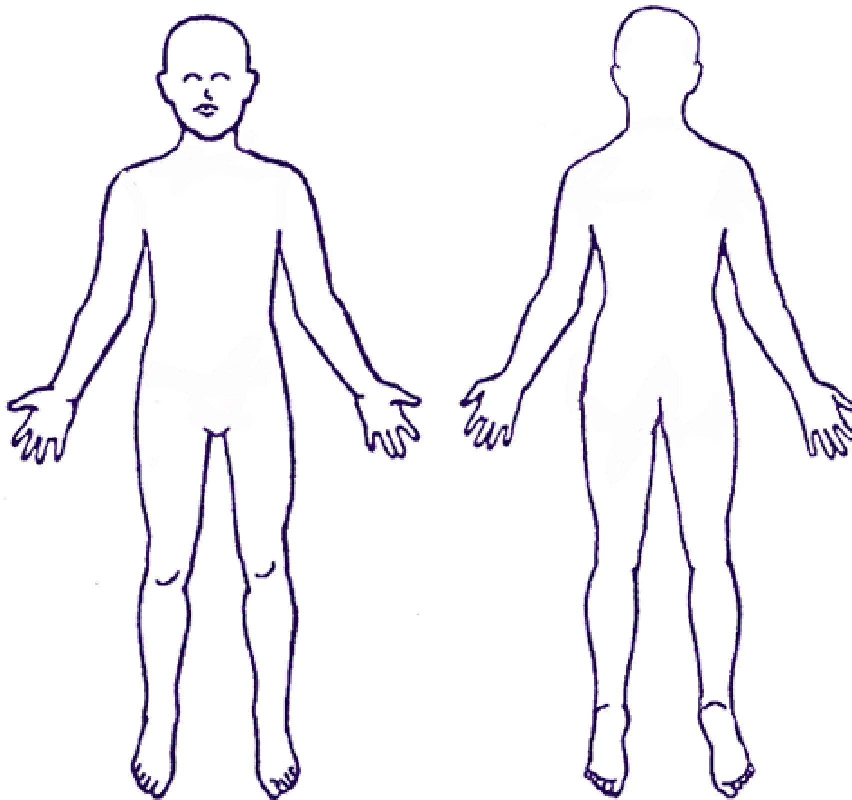
Which medications/treatments have you tried in the past? ______

______

Which medications/treatments is your child currently using? ______

Does your child experience numbness or tingling anywhere in their body? ☐ Yes ☐ No

If so, indicate the location(s) on the drawing:



If your child has any other complaints, select the symptom and explain as needed:

- ☐ Fever?
- ☐ Chills?
- ☐ Weight loss?
- ☐ Eye problems?
- ☐ Ears?
- ☐ Nose?
- ☐ Mouth?
- ☐ Throat?
- ☐ Shortness of breath?
- ☐ Cough?
- ☐ Wheezing?
- ☐ Nausea?
- ☐ Vomiting?
- ☐ Constipation?
- ☐ Diarrhea?
- ☐ Heart problems?
- ☐ Muscle pain?
- ☐ Joint pain?
- ☐ Urination problems (burning, frequency)?
- ☐ Back/neck pain?
- ☐ Shoulder pain?
- ☐ Weakness?
- ☐ Skin rash?
- ☐ Dizziness?
- ☐ Lightheadedness?
- ☐ Memory loss?
- ☐ Trouble with speech or swallowing?
- ☐ Numbness/tingling?
- ☐ Headaches?
- ☐ Nasal stuffiness?
- ☐ Sensation of "flushed face"?
- ☐ Numbness or tingling anywhere in the body?
- ☐ Loss of appetite?
- ☐ Crying spells or feeling sad?
- ☐ Insomnia?

Comments: ____

____

____

Texas Comprehensive Spasticity Center
6410 Fannin, Suite 950
Houston, Texas 77030

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Physical, Occupational and Speech Therapy

Physical Therapy

Has your child participated in physical therapy in the past 4 months? ☐ Yes ☐ No

For school-based therapy, what is the setting of therapy? ☐ Group ☐ Individual ☐ None Frequency: ____________

If participating in school-based program, what are the goals/focus of the program? ____________________________________

____

For clinic or home-based therapy, what is the setting of therapy? ☐ Group ☐ Individual ☐ None Frequency: ____________

If participating in clinic or home-based program, what are the goals/focus of the program? ____________________________

____

Occupational Therapy

Has your child participated in occupational therapy in the past 4 months? ☐ Yes ☐ No

For school based therapy, what is the setting of therapy? ☐ Group ☐ Individual ☐ None Frequency: ____________

If participating in school based program, what are the goals/focus of the program? ____________________________________

____

For clinic or home based therapy, what is the setting of therapy? ☐ Group ☐ Individual ☐ None Frequency: ____________

If participating in clinic or home based program, what are the goals/focus of the program? ____________________________

____

Speech Therapy

Has your child participated in speech therapy in the past 4 months? ☐ Yes ☐ No

For school based therapy, what is the setting of therapy? ☐ Group ☐ Individual ☐ None Frequency: ____________

If participating in school based program, what are the goals/focus of the program? ____________________________________

____

For clinic or home based therapy, what is the setting of therapy? ☐ Group ☐ Individual ☐ None Frequency: ____________

If participating in clinic or home based program, what are the goals/focus of the program? ____________________________

____

List any previous therapy, including intensives, and the dates/locations if applicable: ____________________________________

____

Additional information for the team, regarding therapy, home program, or goals: _______________________________________

____

Are there any questions we can answer for you at this visit? ____

____