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**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
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<tr>
<td>Today's Date</td>
<td></td>
</tr>
<tr>
<td>Home Phone Number</td>
<td></td>
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<tr>
<td>Cell Phone Number</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male/Female</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
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<tr>
<td>State</td>
<td></td>
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<tr>
<td>Zip Code</td>
<td></td>
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<tr>
<td>Email Address</td>
<td></td>
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<tr>
<td>Emergency Contact</td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
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</tbody>
</table>

**Care Team**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric</td>
<td></td>
</tr>
<tr>
<td>Neurologist</td>
<td></td>
</tr>
<tr>
<td>Physical Medicine &amp; Rehab Physician</td>
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<tr>
<td>Last Seen</td>
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<tr>
<td>Orthopedic Physician</td>
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<tr>
<td>Last Seen</td>
<td></td>
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<tr>
<td>Physical Therapist</td>
<td></td>
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<tr>
<td>Phone Number</td>
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<tr>
<td>Occupational Therapist</td>
<td></td>
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<tr>
<td>Phone Number</td>
<td></td>
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<tr>
<td>Speech Therapist</td>
<td></td>
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<tr>
<td>Phone Number</td>
<td></td>
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<tr>
<td>ECI Contact Information</td>
<td></td>
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<tr>
<td>Other MD/Specialty</td>
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<tr>
<td>Other MD/Specialty</td>
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<tr>
<td>Outpatient Therapy Clinic</td>
<td></td>
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<tr>
<td>Home Health Company</td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

**Referral Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Referring Physician</td>
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</tr>
<tr>
<td>Phone Number</td>
<td></td>
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<tr>
<td>Address</td>
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<tr>
<td>City</td>
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<tr>
<td>State</td>
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<tr>
<td>Zip Code</td>
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</table>

**Pregnancy**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>Select any complications experienced during pregnancy:</td>
<td></td>
</tr>
<tr>
<td>☐ Preterm labor</td>
<td></td>
</tr>
<tr>
<td>☐ Fetal Anomalies</td>
<td></td>
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<tr>
<td>☐ Placental Abruption</td>
<td></td>
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<tr>
<td>☐ IUGR</td>
<td></td>
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<tr>
<td>☐ Oligohydramnios</td>
<td></td>
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<tr>
<td>☐ None</td>
<td></td>
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<tr>
<td>☐ Other</td>
<td></td>
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<tr>
<td>Born at ______ weeks gestation</td>
<td></td>
</tr>
<tr>
<td>Birth Weight</td>
<td></td>
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<tr>
<td>Birth Length</td>
<td></td>
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<tr>
<td>FOC</td>
<td></td>
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<tr>
<td>Delivery: ☐ Vaginal ☐ C-Section</td>
<td></td>
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<tr>
<td>Anesthesia Given: ☐ Yes ☐ No</td>
<td></td>
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<tr>
<td>Reason for C-Section/Anesthesia:</td>
<td></td>
</tr>
<tr>
<td>Apgar Scores (if known): 1 minute:</td>
<td></td>
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<tr>
<td>5 minutes:</td>
<td></td>
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<tr>
<td>10 minutes:</td>
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</table>
### Condition of Baby at Delivery & in Nursery

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

Select any conditions present at delivery:

| ☑ Jaundice                | ☑ Hydrocephalus              | ☑ Prematurity – Intra-ventricular Hemorrhage (Grade: ________) |
| ☑ Needed Oxygen           | ☑ Hypoxic Ischemic Encephalopathy | ☐ Prematurity – Peri-ventricular Leukomalacia                  |
| ☑ Shunt Placement/Revision | ☑ Congenital Stroke           | ☐ Genetic Condition:                                          |
| ☑ ETV                     | ☑ Brain Malformation          |                                                                 |
| ☑ Ventilator              | ☑ Prematurity – Multiple Injuries |                                                               |
| ☑ Seizure Medications     |                                |                                                                 |

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: ________________________________

<table>
<thead>
<tr>
<th>☑ Yes ☐ No</th>
<th>☑ Yes ☐ No</th>
<th>☑ Yes ☐ No</th>
<th>☑ Yes ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child require a tracheostomy?</td>
<td>Does your child require a ventilator?</td>
<td>Has your child been hospitalized in the past 12 months?</td>
<td>Has your child had pneumonia/respiratory infection in the past 12 months?</td>
</tr>
<tr>
<td>Has your child have a previous history of cancer or tumors?</td>
<td>If so, please describe the location: __________________________________________</td>
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</tr>
<tr>
<td>Has your child received treatment for a wound in the last two months?</td>
<td>☑ Yes ☐ No</td>
<td></td>
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<tr>
<td>If so, please describe: __________________________________________</td>
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</table>

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

<table>
<thead>
<tr>
<th>☑ Yes ☐ No</th>
<th>Date: __________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your child received a pneumonia immunization?</td>
<td>Has your child received an influenza immunization?</td>
</tr>
<tr>
<td>Are your child’s other childhood immunizations up to date?</td>
<td>☑ Yes ☐ No</td>
</tr>
</tbody>
</table>

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 your 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/has 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 a bowel routine? □ Yes □ No

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  
Phone: 832-325-7242  
Fax: 713-512-2220
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? ______________________________________

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