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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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:

_____

_____

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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: _____

_____

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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

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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? _____

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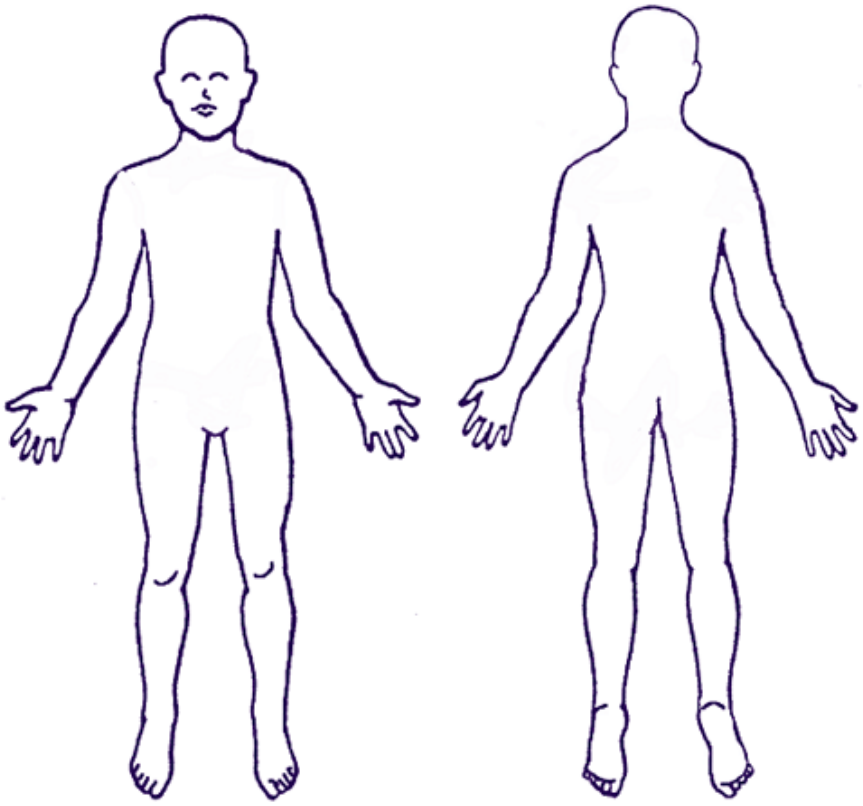
Does your child experience numbness or tingling anywhere in their body? ☐ Yes ☐ No

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: _____

_____

_____

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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? _____

_____

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