# Physical Therapy Evaluation (PT)



| Study ID # | Patient Initials | Date of Evaluation | Study | Study Visit Number |
|---|---|---|---|---|
| ☐☐☐☐ | ☐☐☐ | ☐☐ - ☐☐ - ☐☐☐☐<br>Month Day Year | ☐ Natural History<br>☐ VPA ☐ PBA | ☐ S1 ☐ S2 ☐ S3 ☐ S__<br>☐ V1 ☐ V2 ☐ V3 ☐ V__ |

1. What time was the Physical Therapy Evaluation performed? ☐☐:☐☐ ☐ AM ☐ PM

2. Which Physical Therapy Evaluations were done?

   ☐ Myometry Testing

   ☐ Modified Hammersmith Functional Motor Scale (MHFMS)

   ☐ Project Cure Functional Motor Scale (PCFMS):

   ☐ ROM Testing

## BEHAVIOR DURING TESTING

| | | Comments |
|---|---|---|
| 3. Cooperative | ☐ Yes ☐ No | |
| 4. Child unable to follow directions | ☐ Yes ☐ No | |
| 5. Fussy or crying | ☐ Yes ☐ No | <25% >25% entire session |
| 6. Needed lots of coercion, bribing toys | ☐ Yes ☐ No | |
| 7. Tested out of order | ☐ Yes ☐ No | |
| 8. Currently ill with respiratory or other illness | ☐ Yes ☐ No | |
| 9. Parents report child has not eaten breakfast yet, or meal previous to test session | ☐ Yes ☐ No | looking to see if what they ate was typical for them |
| 10. Parents report child has not slept well previous to testing | ☐ Yes ☐ No | |
| 11. Parents report child can do item when wants to | ☐ Yes ☐ No | Item # |
| 12. Testing is indicative of this child's typical performance | ☐ Yes ☐ No | |

## ORTHOPEDIC / MEDICAL

| | | Comments |
|---|---|---|
| 13. Scoliosis or contractures that limit participation in any item | ☐ Yes ☐ No | |
| 14. Pain that limits participation | ☐ Yes ☐ No | ROM / Myometry / Funtional Testing |
| 15. Has a scoliosis | ☐ Yes ☐ No | Degree, if known_____________ |
| 16. Has a spinal fusion | ☐ Yes ☐ No | |
| 17. Any recent orthopedic procedures or surgery (of any type) that may limit participation | ☐ Yes ☐ No | |

Evaluator's signature ______________________ Date ____________

Project Cure SMA



# Physical Therapy Evaluation (PT)



| Study ID # | Patient Initials | Date of Evaluation | Study | Study Visit Number |
|---|---|---|---|---|
| ☐☐☐☐ | ☐☐☐ | ☐☐ - ☐☐ - ☐☐☐☐<br>Month Day Year | ☐ Natural History<br>☐ VPA ☐ PBA | ☐ S1 ☐ S2 ☐ S3 ☐ S__<br>☐ V1 ☐ V2 ☐ V3 ☐ V__ |

## BRACING FOR FUNCTION (Looking for change during study)

| | | Comments |
|---|---|---|
| 18. Inserts of any type | ☐ Yes ☐ No ☐ NA | Includes pattibobs, arch supports, etc. |
| 19. SMO | ☐ Yes ☐ No ☐ NA | |
| 20. DAFO (Not SMO's) | ☐ Yes ☐ No ☐ NA | Any cascade orthotic. Note Style _____________ |
| 21. AFO | ☐ Yes ☐ No ☐ NA | ☐ Solid ☐ Articulating |
| 22. KAFO | ☐ Yes ☐ No ☐ NA | |
| 23. Is KAFO Ischial weight bearing? | ☐ Yes ☐ No ☐ NA | |
| 24. HKAFO | ☐ Yes ☐ No ☐ NA | |
| 25. RGO | ☐ Yes ☐ No ☐ NA | |
| 26. Stander | ☐ Yes ☐ No ☐ NA | |
| 27. Body Jacket / TLSO | ☐ Yes ☐ No ☐ NA | |
| 28. Other: ____________ | ☐ Yes ☐ No ☐ NA | ☐ Knee Sleeves ☐ Just got new braces, not yet using routinely |

## SPLINTS FOR ROM/CONTRACTURES

| | | Comments |
|---|---|---|
| 29. Ankle splints | ☐ Day Only ☐ Night Only ☐ Day and night ☐ NA | |
| 30. Knee splints | ☐ Day Only ☐ Night Only ☐ Day and night ☐ NA | |
| 31. Hand splints | ☐ Day Only ☐ Night Only ☐ Day and night ☐ NA | |
| 32. Other: ___________ | ☐ Day Only ☐ Night Only ☐ Day and night ☐ NA | |

Evaluator's signature ______________________________ Date ____________



Property of FSMA

# Physical Therapy Evaluation (PT)



| Study ID # | Patient Initials | Date of Evaluation | Study | Study Visit Number |
|---|---|---|---|---|
| ☐☐☐☐ | ☐☐☐ | ☐☐ - ☐☐ - ☐☐☐☐<br>Month Day Year | ☐ Natural History<br>☐ VPA ☐ PBA | ☐ S1 ☐ S2 ☐ S3 ☐ S__<br>☐ V1 ☐ V2 ☐ V3 ☐ V__ |

## STANDING, MOBILITY, AMBULATION (What child typically can do)

| | | Comments |
|---|---|---|
| 33. Does child stand?<br>If yes, answer 34-38 | ☐ Yes ☐ No | |
| 34. Independent (no assist, braces or help) | ☐ Yes ☐ No | |
| 35. Uses stander | ☐ Yes ☐ No | |
| 36. Uses braces | ☐ Yes ☐ No | |
| 37. Uses assistive devices | ☐ Yes ☐ No | |
| 38. Time tolerated per day | ☐ Minutes | |
| 39. Does child walk?<br>If yes, answer 40-44 | ☐ Yes ☐ No | If use asstive device for walking but not for standing, then note in comments |
| 40. Independently | ☐ Yes ☐ No | Can use braces or walker, but no physical help |
| 41. Uses braces to walk | ☐ Yes ☐ No | |
| 42. Uses assistive device to walk (walker,etc) | ☐ Yes ☐ No | |
| 43. How long (time) per day? | ☐ Minutes | |
| 44. How far (distance) per day? | ☐ Feet | |
| 45. Manual wheelchair | ☐ Yes ☐ No | |
| 46. Power wheelchair | ☐ Yes ☐ No | |
| 47. Other Mobility Device | ☐ Yes ☐ No | ☐ Scooter ☐ Stroller ☐ Standing Danny |

## ADDITIONAL COMMENTS

48. Comments

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

Evaluator's signature ______________________ Date ____________