Centre for the Rehabilitation of the Paralysed (CRP)

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Combined Assessment Form for Physiotherapy & Occupational Therapy

Paediatric Unit

Name: Age: Sex:

Father's Name: Date of birth:

Address:

Village/House No: Post Office:

PS: Dist: Telephone:

Referred by:

Referring Diagnosis: Occupational Therapist:

Date of referral: Physiotherapist:

Part-1

Date of Assessment:

Family history: First cousin marriage: Yes_____ No _____

Mother's health: **Father's health:**

Literacy/ Education: Literacy/ Education:

Employment: Employment:

Siblings: Number_____ Age _____ Disabilities _____

History of present condition: (Parents perception of the problem and expectations)

Milestones: Independent- Rolling _____Sitting _____Walking_____

Birth History: Premature _____Term _____ Post- mature_____

Before birth:

Pregnancy: Deliver of birth is attended by _____

High Blood Pressure_____ At Hospital_____

Anaemia_____ Clinic_____

Other illness _____ Home _____

During Birth:

Prolonged labour _____ Birth Injury _____

Short Labour _____ Birth asphyxia_____

Sudden Birth _____ Minutes until baby cried_____

After birth:

Jaundice: _____ Length of stay at hospital_____

Dehydration _____ Treatment Received _____

Pneumonia _____ UV light _____

Seizures _____ Oxygen_____

Others _____ Medication_____

Investigations:
Consultations (with whom)

CT scan result:

EEG result: X-ray_____

Others:

Medication Treatment:
Drug History: Any present meds._____

Name_____ Reason_____

Therapy treatments: When_____ Where_____ How long_____

What was included?

Others: Village doctor_____ Homeopathy_____Others _____

Previous Medical History:

Epilepsy: Fracture:

1st seizure: Respiratory: Others

Last seizure: Bowels:

Medication: Bladder:

Vision:
Fixing _____ Tracking _____ Horizontal _____ Vertical _____

Nystagmus_____ Glasses _____ Squint_____

Hearing:

Home Environment: Paved road _____ Location of toilet_____

Stairs _____

Home equipment (Seating braces, splints, shoes)

General observations:

Communication:
Does the child communicate by:

Crying _____ Facial expression _____

Making Gestures/ Signs _____ Making sounds_____

Speaking words _____ Speaking sentences _____

Any other means _____

_____ _____ or _____ _____

PT signature Date OT Signature Date

Part-2 Occupational Therapy

SENSORY SKILLS: (Normal/ Hypo/Hyper response)

Tactile

Visual

Auditory

Vestibular

Proprioceptive

NEUROMUSCULAR STATUS:

Tone:

Upper Limb
Lower Limb
Trunk

Range of Movement:

Upper limbs

Lower limbs

FUNCTIONAL GROSS MOTOR:

Sitting

Crawling

Standing

Cruise alone furniture

Walking

Jumping

Running

Ball skills

TRANSITIONAL MOVEMENTS:

Rolling

Pivot prone

Supine to sit

Prone to sit

Sit to stand

Sit to side lying/ prone

Half kneel to stand

Stand to sit

POSTURAL CONTROL: (Head and Trunk) – supine, prone, sit (dynamic, static), standing, prone extension, supine extension.

CLINICAL OBSERVATION: Contractures, Flat feet, Hyperextend Knee, Dislocation, deformities, others.

AUTOMATIC REACTION:

Equilibrium reactions

Protective reactions

GRAVITATIONAL INSECURITY:

PRIMITIVE REFLEXES: ATNR, STNR, Moro, Landau, Flexor withdrawal, Labyrinthine
Others_____

PERCEPTUAL MOTOR:
Body Awareness

Body Co- ordination

Bilateral Integration

VISUAL PERCEPTION:
Visual Discrimination

Visual Memory

Visual Figure ground

Visual Spatial

COGNITIVE SKILLS:
Level of arousal

Attention /hyperactivity/attention span

Problem solving

Able to follow instructions

FINE MOTOR SKILLS: Dominance: Right _____ Left_____

Reach:

Grasp type:

Release:

Symmetrical use:

Bilateral use:

In- hand manipulation:

Eye hand co-ordination:

Transfer:

Writing skills:

BEHAVIOUR:

Including incidence of aggression, hyperactivity, following instructions, interaction with other children, discipline, others.

OCCUPATIONAL PERFORMANCE:
Feeding:

Bursting teeth:

Dressing:

Toilet:

Bathing:

DOES THE CHILD ATTEND SCHOOL? No _____ Yes _____ Grade_____

LEISURE/PLAY: activities of interest-

ORAL MOTOR CONTROL
Observation: (tone, reflexes and oral motor control)

Behaviour and interaction in feeding:

Posture in Feeding:

Type of Foods: Drooling:

Choking/Gagging: Chewing:

Swallow: Drinking:

Suck: Tongue thrust:

_____ _____

OT Signature Date

Part – 3 Physiotherapy

GENERAL OBSERVATIONS:

MUSCLE TONE: (decreased, minimal/ moderate/ max increased, fluctuating present at rest/ with movement, predominant posture, right/ left)

Upper Limbs: Rt Lt

Lower limbs:

Trunk/ neck:
Passive range of movement (WNT- within normal limit, ERT- end range tightness, or measure degrees with goniometry if any limitations)

Hip	Right	Left	shoulder	Rt	Lt
Extension			Flexion		
Flexion			Extension		
Ab/ Add			Abduction		
Rotation			Rotation		
Knee			Elbow		
Flexion/ ext			Flexion/ extension		
Ankle			Sup/ pro		
DF/ PF			Wrist		
Inv/ ever			Flexion/ ext		
Toes			Finger		

SPINE ROM:

FUNCTIONAL GROSS MOTOR

- Note the posture of the child's head shoulders, arm trunk, pelvis, knee, feet, weight bearing, symmetry and tone patterns or abnormal reflex activity.
- Ability to get in/out of position, to maintain it, support needed to be symmetrical, to maintain head control, to either side to bear and shift weight, and presence and effectiveness of protective and equilibrium reaction, co-ordination comment on muscle strength, if appropriate

Prone:

Supine:

BRIDGING:

Box sitting:

Floor: preferred position:

Long sitting:

Cross sitting:

4 point kneeling:

Crawling:

Mobility: Main mode of mobility:

Squatting:

High kneeling

½ kneeling:

Standing:

Kneel walking:

Gait:

Stairs:

Single leg stance:

Running

Jumping:

Hopping

Ball skills:

TRANSITIONAL MOVEMENTS:

Rolling Supine to Prone:

Prone to Supine

Continuous Rolling:

Lying to Sit

Box Sit to Stand

Cross sit to stand

Fine Motor Function

PT Signature

Date

Physiotherapy Diagnosis:

PT Problem List:

Treatment Plan:

Short Term Goals:

Date Achieved:

Long Term Goals:

Date Achieved:

PT Signature

Date

Occupational Therapy Impression/ Diagnosis:

OT Problem List:

Treatment Plan:

Short Term Goals:

Date Achieved:

Long Term Goals:

Date Achieved:

OT Signature

Date

Part- 4 Equipments Selection

(Equipments plan-Selected by Occupational Therapist & Physiotherapist together)

Equipments

Arm splints (Resting/ cock-up/ writing splint)

Gaiter leg/ arm

Leg braces

Shoes/ shoes with arches

Standing frame

Walking aids

AFO/ KAFO

Seating: Corner chair/ wooden chair/ special chair

Dressing/ feeding aids

Spinal brace

Positioning equipment

Others

Referred to:

OT Department

Orthotic department

Special seating

Special needs school

Others

PT signature _____ Date _____ or OT Signature _____ Date _____

Outcome measurement Form
Physiotherapy Paediatric Unit, CRP

Reg. /Case no.....

Patients name: _____ Admission Date: _____

Age: _____ Assessment Date: _____

Sex: _____ Name of Physiotherapist: _____

Diagnosis: _____ Evaluation Date: _____

Address: _____

_____

Gross Motor Skills

FIM Scale

LEVEL	1	Total assistance or unplaceable in position	Needs Helper or Device
	2	Maximum Assistance required (child does 25% of the work	
	3	Moderate Assistance required (child does 50% of the work	
	4	Minimal Assistance required (child does 75% of the work	
	5	Required Supervision	
	6	Modified independence (abnormal movement patterns or not able to dynamically move from the base of support. If a balance activity, is able to for greater than 30 seconds)	No Helper
	7	Complete independence (full dynamic movement and able to maintain balance for than 30 seconds)	

Starting position	Admission	Discharge	1st Follow-up 6/12
Rolling Supine to Prone to L			
Rolling Supine to Prone to R			
Rolling Supine to Prone to L			
Rolling Supine to Prone to R			
Moving from Supine to box sitting			
Sitting on box			
Moving from box sitting to standing			
4 point kneeling			
Supine to cross sitting through left side lying			
Supine to cross sitting			

through right side lying			
Sitting in cross leg sitting			
Cross leg sitting into 2 cycles of crawling			
Cross leg sitting to standing			
Standing			
Squatting			
High kneeling			
Walk on knees			
½ kneeling			
Walking 5 metres			
Running			
Jumping (3 consecutive jumps)			
Hopping (3 consecutive hops on each leg) Rt			
Hopping (3 consecutive hops on each leg) Lt			
Single leg stance			
Ascending 4 steps			
Descending 4 steps			
Total Score			

Range of movement

WNL = With Normal Limits, ERT = End Range Tightness or Specific ROM with goniometer

		Admission		Discharge		6/12 Follow up	
		Rt	Lt	Rt	Lt	Rt	Lt
Upper limb	Shoulder						
	Elbow						
	Wrist						
	Fingers						
Lower limb	Hip						
	Knee						
	Ankle						
	Toes						

Signature and Date

CENTRE FOR THE REHABILITATION OF THE PARALYSED (CRP)
PAEDIATRIC UNIT
OCCUPATIONAL THERAPY EVALUATION FORM

Name of patient: Diagnosis:	Age:	Sex: M/F Indoor/ Out door

Caregiver Assistance Scale:

5 = independent	2 = Moderate Assistance
4 = supervision	1 = Maximum Assistance
3 = Minimum Assistance	0 = Total Assistance

	VISIT NUMBER	1	2	3	4	5	6	7
A	**SELF-CARE DOMAIN**							
1	**Eating:** Eating and drinking regular meal; do not include cutting steak, opening containers or serving food from serving dishes.							
2	**Grooming:** Brushing teeth, brushing or combing hair and caring for nose.							
3	**Bathing:** Washing and drying face and hands, taking a bath or shower; do not include getting in and out of a tub or shower, water preparation, or washing back or hair.							
4	**Dressing Upper Body:** All indoor clothes, not including back fasteners; include help putting on or taking off splint; do not include getting clothes from closet or drawers.							
5	**Dressing Lower Body:** All indoor clothes include putting on or taking off brace, do not include getting clothes from closet or drawers.							
6	**Toileting:** Clothes, toilet management or external device use, and hygiene, do not include toilet transfers, monitoring schedule, or cleaning up after accidents.							
7	**Bladder Management:** Control of bladder day and night, monitoring schedule.							
8	**Bowel Management:** Control of bowel day and night, monitoring schedule.							
	Self-care Totals							
B	**MOBILITY DOMAIN**							
1	**Bed Mobility:** getting in and out and changing positions in child's own bed.							
2	**Chair, Box/ Toilet Transfers:** Ability to transfer on chair, box/ toilet.							

	VISIT NUMBER	1	2	3	4	5	6	7
3	**Crawling:** Ability to Crawls on bed or floor							
4	**Indoor Locomotion:** 50 feet (3-4 rooms); do not include opening doors or carrying objects.							
5	**Outdoor Locomotion:** 150 feet (15 car lengths) on level surfaces; focus on physical ability to move outdoors.							
6	**Stairs:** Climb and descend a full flight of stairs (12-15 steps).							
	Mobility Totals							
C	**HAND SKILLS**							
1	**Reaching:** Ability to reaching object to midline							
2	**Grasp:** Ability to grasping any type of object							
3	**Release:** Ability to release the object in hand							
4	**Bilateral use:** Ability to use both hand for function							
5	**Transfer:** Transferring any object one hand to another hand or place.							
6	**Writing:** Ability to writing words or sentence							
	Hand Skills Totals							
D	**SOCIAL FUNCTION DOMAIN**							
1	**Functional Comprehension:** understanding of requests and instructions.							
2	**Functional Expression:** ability to provide information about own activities and make own needs known, include clarity of articulation.							
3	**Joint Problem Solving:** include communication of problem and working with caregiver or other adult to find a solution; include only ordinary problems occurring during daily activities; (for example, lost toy; conflict over clothing choices).							
4	**Peer Play:** ability to plan and carry out joint activities with a familiar peer.							
5	**Safety:** caution in routine daily safety situations, including stairs, sharp or hot objects and traffic.							
	Social Function Totals							

Assessors' Name & Signature with Date:

1.

2.

3.

4

5.

6.

7.