Check List

For

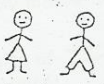
C.P Child

(With Guidelines)

File Number	TYPE OF DISABILITY	Future action:	Date:	Done:	RECOR SHEET 1 (page 1
Code	Movement _____	_____ come back again	_____	_____	
	Deformity _____	_____ refer to specialist	_____	_____	
	Retarded _____	_____ visit at home	_____	_____	
	Blindness _____	_____ other _____	_____	_____	
	Deafness _____				
	Speech _____				
	Fits _____				
	Behavior _____				
	Other _____				

Specific disability if known: _____

CHILD'S HISTORY (First visit)

Name: _____ Sex: 

Date of birth: _____ Address: _____

Age: _____ Weight: _____ Height: _____ _____

Mother: _____ _____

Father: _____ Telephone: _____

How did you learn about the program? _____

WHAT IS THE CHILD'S MAIN PROBLEM? _____

_____

_____

When did it begin? _____ How? (Cause?) _____

Other problems? _____

Is the disability improving? _____ Getting worse? _____ About the same? _____

Explain: _____

How do you hope your child will benefit from coming here? _____

Do other family members or relatives have a similar problem? _____ Who? _____

Has the child received medical attention? _____ What? _____

_____ Where? _____

Use any braces or other aids? _____ What? _____

Has he used any in the past? _____ Explain: _____

_____

How is the child's general health? _____

Is he fat? _____ Very thin? _____ Other? _____

Hears and sees well? _____ Explain: _____

Comment on the child's developmental abilities or difficulties:

	normal for age?
head control	
use of hands	
creeping or crawling	
standing, walking	
play	
feeding or drinking	
toileting	
personal hygiene	
dressing	

Does the child speak? _____ How much or well? _____ Began when? _____

What other things can the child do? _____

_____

What things can the child not do? _____

_____

What new skills or abilities would you like to see your child gain? _____

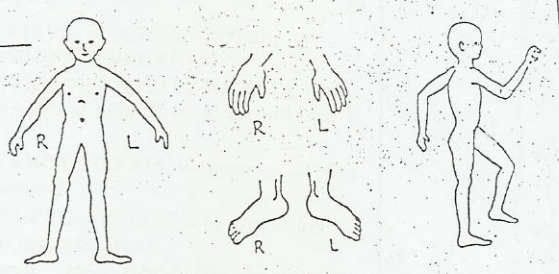
_____

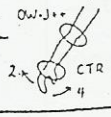
SAMPLE RECORD SHEET FOR PHYSICAL EXAM

RECORD SHEET 2

Child's name _____

File number _____



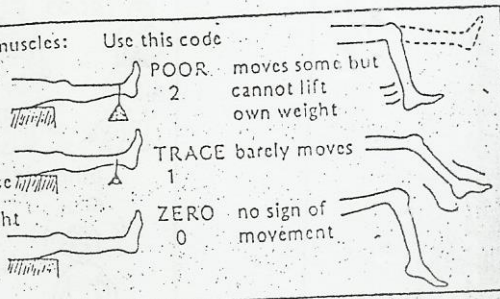
Mark on the drawings where you find the problems. Use lines and circles together with abbreviations shown on this page. For example: → 

Where necessary, make new drawings on another sheet.

Parts of body affected

L or R _____ other _____ (indicate)

Strength or weakness of muscles: Use this code



NORMAL 5 — lifts and holds against strong resistance

GOOD 4 — moves against some resistance

FAIR 3 — lifts own weight but no more

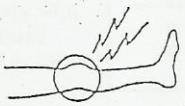
POOR 2 — moves some but cannot lift own weight

TRACE 1 — barely moves

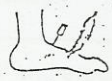
ZERO 0 — no sign of movement

OW: Pain OW-J pain in joints OW-M pain in muscles

0 none
+ little
++ a lot
+++ so much that she does not move it



T: ability to feel, touch, pain, etc.



R or L	normal	*reduced	*absent
other			

Problems with

___ *Eyes or sight. What: _____

___ *Ears or hearing. What: _____

CTR: contractures

___ tight muscles do not yield with pressure

SP: spasticity

___ *tight muscles yield slowly with pressure

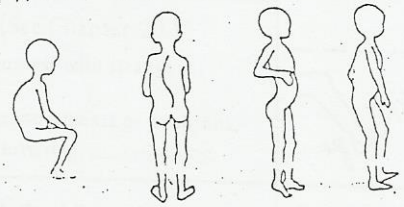
Deep tendon reflexes:

Right knee
Left knee
Other _____

*nothing 0	*little +	normal ++	*brisk +++	*extreme ++++

Spine

hunchback (kyphosis) — sideways curve (scoliosis) — swayback (lordosis) — hard bump (TB?)



curve fixed ___ curve can straighten ___ (See p. 161.)

HT: hips tilt

R leg shorter ___ by ___ cm
L leg shorter ___

DL: dislocations:

hip _____
knee _____
elbow _____
other _____

R	L	from birth	old	new

***Spina bifida**

back already operated ___ date ___

head already operated ___ date ___

extent of paralysis _____

extent of feeling lost _____

***Spinal cord injury**

what level _____

	Good	Poor	None
Bowel control			
Bladder control			

Other problems

___ *pressure sores
___ *unusual movements
___ *tremors
___ *fits
___ *poor balance
___ *developmental delay

IMPORTANT: This form does *not* cover all the tests and information you will want to record when examining a child. Put other information on the back of this sheet. Or use separate sheets or forms.

*If you check any problem area marked with a star (*), a more complete check of the nervous system is needed. You can use the RECORD SHEETS 3, 4, and 6.

RECORD SHEET: ADDITIONAL TESTS AND OBSERVATIONS OF THE NERVOUS SYSTEM

RECORD SHEET 3

These tests are *often not needed* but may sometimes be useful when you are not sure if a child has *brain damage*. For other signs of brain damage, see Chapter 9 on Cerebral Palsy. For tests of seeing and hearing, see p. 447 to 454.

Eye movement

___ eyes jerk, flutter, or roll up unexpectedly and repeatedly (brain damage, possible epilepsy—p. 233)

___ one eye looks in a different direction or moves differently from the other (possible brain damage)

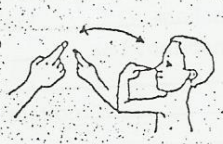
Move finger or toy in front of eyes from side to side and up and down.

___ eyes follow smoothly (normal)

___ eyes follow in jumps or jerks (possible brain damage)

Eye to hand coordination

___ moves finger from nose to object and back again almost without error—with eyes open, and also closed (normal)



___ misses or has difficulty with eyes open (poor coordination, poor balance, or loss of position sense)

___ has much more difficulty with eyes closed (loss of position sense)

Body movements

___ awkwardness or difficulty in controlling movements

___ sudden or rhythmic uncontrolled movements

___ parts of body twist or move strangely when child tries to move, reach, walk, speak, or do certain things

(All these may be signs of brain damage; see Chapter 9.)

Details of any of the above: _____

Fits of different kinds (See Chapter 29.)

___ sudden loss of consciousness with strange movements,

___ brief periods of strange movements or positions,

___ blank stares, ___ eye fluttering, ___ twitching.

Developmental delay: Is the child unable to do many different things that others her age can do? Which? (See Chapter 34.)

___ head control
___ use of hands
___ rolling
___ creeping and crawling
___ sitting
___ standing and walking
___ sucking
___ eating
___ playing
___ communication or speech
___ behavior
___ self-care activities

Balance

With the child in a sitting or standing position, gently rock or push him off balance.

___ CHILD DOES NOT TRY TO KEEP FROM FALLING (poor balance—sign of brain damage in child over 1 year)

___ CHILD TRIES NOT TO FALL by putting out his hands (fair balance)

___ CHILD KEEPS FROM FALLING by correcting body position (good balance)

GOOD POOR GOOD POOR

Balance test for the older, more stable child

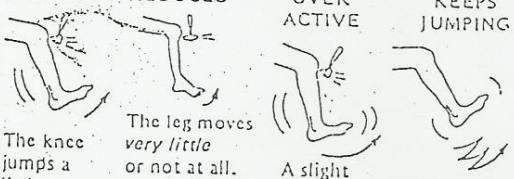
Have child stand with feet together.

___ balance difficulty with eyes open—may be brain damage (or muscle-joint problem)

___ balance difficulty much greater with eyes closed (probably nervous system damage)

'Knee jerks' and other 'muscle jump' reflexes

With the leg relaxed and partly bent, tap the cord just below the knee cap.



NORMAL	REDUCED	OVER ACTIVE	KEEPS JUMPING
The knee jumps a little.	The leg moves *very little* or not at all. Typical of polio, muscular dystrophy, and other floppy paralyses.	A slight tap causes a *big jump*. Typical of spasticity from cerebral palsy, spinal cord injury, and other brain or spinal cord damage.	One tap causes the limb to jerk many times. Happens with spinal cord injury and some cerebral palsy.

You can also tap the heel cord and other cords near joint.

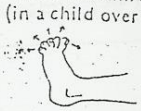
Great toe reflex

Stroke the foot toward the toe with a somewhat pointed object (like a pen).

NORMAL

toes bend down

NOT NORMAL (in a child over 2)



toes bend up and spread

This is a sign of brain or spinal cord damage (Babinski's sign) May occur in a normal child under 2 years.

RECORD SHEET 1 (page 2)

s child mentally normal? _____
etarded? _____ How severely? _____
hy do you think so? _____
s the child have fits? _____ How often? _____
scribe: _____
es medicine? _____ What? _____
r what? _____ Results (good or bad): _____
havior normal for age? _____
havioral or emotional problems? _____ Explain: _____

oes to school? _____ What year? _____
ith whom does the child live? _____
umber of brothers and sisters: _____ Ages: _____
[illegible]? _____ [illegible]? _____

AVERAGE EARNINGS

other works? _____ At what? _____
he child seems: well-cared for? _____ spoiled or overprotected? _____
neglected? _____ happy? _____ self-confident? _____ withdrawn? _____
other? _____
mportant details of family situation: _____

What has the family done, made, or obtained to help the child function better? _____

Other observations, information or drawings:
(Use an additional sheet if necessary.)

History of illness	Date
measles	
chicken pox	
whooping cough	
other	

Vaccinations:	How many	Dates	Allergies
polio			
D.P.T.			
measles			
BCG (TB)			
Other			

How much have you spent for your child's disability? _____ For what? _____

Were disability or complications caused by improper medical treatment or therapy? _____
Explain: _____

FOR CHILDREN WITH POLIO:
Was your child injected within 2 weeks before getting polio? _____
If so, was he or she injected on the side that became most paralyzed? _____

EXAMINATION 4

RECORDS OF FACTORS POSSIBLY AFFECTING CHILD DEVELOPMENT
(mainly for children with possible brain damage or developmental delay)

RECORD SHEET 4

Added history

Was the child born before 9 months? _____ at how many months? _____
Was the child born smaller or thinner than normal? _____ weight at birth? _____
Was the birth of the child normal? _____ slow or difficult? _____
Explain: _____
Did the child seem normal at birth? _____ If not, describe problems: delayed breathing? _____
very floppy? _____ other? _____
Did the mother have problems in pregnancy? _____ German measles _____ at _____ months.
Other? _____ Medicines or drugs during pregnancy: _____ What? _____
Age of mother _____ and father _____ at time of child's birth.

Physical exam

Does the child show signs of brain damage? (Use RECORD SHEETS 3 and 4.)
What? _____
Does the child show signs of Down syndrome (mongolism)? _____
What? (wide, slanted eyes _____, crease in hand _____, other _____. See p. 279.)
Other physical signs, possibly related to retardation _____
Does the child's head seem smaller _____ or larger _____ than normal?
Distance around head? _____ cm. Difference from normal _____ cm.
Average at her age (from chart) _____ cm. Difference from average _____ cm.

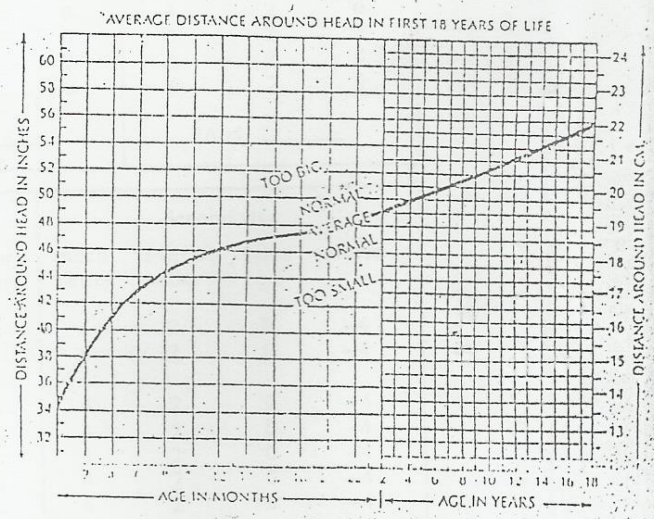
Record of the child's head size

On the chart put a dot where the up-and-down line of the child's age crosses the sideways line of her head size:

Measure around the widest part of the head.

If the dot is *below* the shaded area the head is smaller than normal. The child may be microcephalic (small-brained, see p. 278).

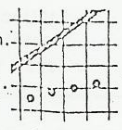
If the dot falls *above* the shaded area, the head is bigger than normal. The child may have hydrocephalus (see p. 169).



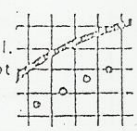
Note: Boys' heads average from ½ to 1 cm. larger than girls' heads. Also head size may vary somewhat with different races. If possible get local charts.

Use the chart for a continuing record. Every month put a new dot on the chart.* If the difference from normal increases, the problem is more likely to be serious. For example,

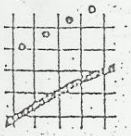
Brain not growing much. Probably microcephalic.



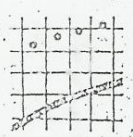
Brain growing well. Probably not serious.



Head too big; growing fast. Hydrocephalus or tumor. Getting worse.



Large head. Probably not a problem.



*Filling out this chart every month is especially important for children with spina bifida or suspected hydrocephalus (see p. 169). If you do not know how to use the chart, ask a local schoolteacher.

EVALUATION OF PROGRESS – CHILD OVER AGE 5

RECORD SHEET 5

Name _____ Age _____ Disability _____

CHART A

Daily activities	First visit (date ____) without help	little help	lots of help	Second visit (date ____) without help	little help	lots of help
Feeding						
1. How does the child eat?	4	2	0	4	2	0
2. How does the child drink?	4	2	0	4	2	0
Dressing and washing						
3. Does child wash face and body?	4	2	0	4	2	0
4. Does child dress?	4	2	0	4	2	0
5. Does child put on orthopedic equipment?	4	2	0	4	2	0
Bowel and bladder care and control						
6. Does child stay clean (bowel control)?	4	2	0	4	2	0
7. Does child clean herself after shitting?	4	2	0	4	2	0
8. Does child stay dry during the day?	4	2	0	4	2	0
9. Does child stay dry at night?	4	2	0	4	2	0
Mobility/transfers						
10. Does child move from chair to bed and back?	4	2	0	4	2	0
11. Does child move from floor to bed and back?	4	2	0	4	2	0
Movement						
12. Walks on flat surface?	4	2	0	4	2	0
13. Walks on uneven surface?	4	2	0	4	2	0
14. Climbs up and down stairs?	4	2	0	4	2	0
15. Uses a wheelboard or wheelchair?	4	2	0	4	2	0
16. Does child crawl?	4	2	0	4	2	0
Social activities/communication						
17. Does child help with housework or farm work?	4	2	0	4	2	0
18. Does child play with other children?	4	2	0	4	2	0
19. Does child go to school?	4	2	0	4	2	0
20. Does child speak?	4	2	0	4	2	0
21. Does child communicate with signs or gestures?	4	2	0	4	2	0
	Total _____			Total _____		

CHART B

Quality of activities	First visit make notes for comparison here	Second visit much better	a little better	same	worse
Does child move about better?		4	2	0	–4
Does he sit in a better position?		4	2	0	–4
Does he walk better (straighter, with less limp, or with less support)?		4	2	0	–4
Does he walk farther, faster, or easier?		4	2	0	–4
Are his joints straighter (less contractures)?		4	2	0	–4
hip?		4	2	0	–4
knee?		4	2	0	–4
ankle?		4	2	0	–4
Can the child do things he could not do before?		4	2	0	–4
feeding?		4	2	0	–4
bathing?		4	2	0	–4
dressing?		4	2	0	–4
toileting?		4	2	0	–4
Does he play with things better?		4	2	0	–4
Does he speak or communicate better?		4	2	0	–4
Does he get along with other children better?		4	2	0	–4
Does he seem happier or more self-confident?		20	8	0	–4
Has he improved or got worse in other ways?		4	2	0	–4
In what ways? _____		4	2	0	–4
		Total _____			