

Motor Function

Today's Date: _____ First and Last Name: _____ Age in Years: _____

1. What is the affected individual's current wheelchair use?

- Full time – Indicate at what age full time wheelchair use began: _____
- Part time, walking short distances independently
- Not at all

2. Is the affected individual able to change position in bed (turn/roll over) on their own?

- Yes, able to roll over from front to back or back to front
- Yes, only able to roll onto side
- Not able to roll unassisted

Motor Function	Function ever achieved?	Function still maintained?	If able in the past, but not currently, specify age in years ability was lost
a. Jump on one foot (foot leaving ground):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Run (both feet leaving ground):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Climb stairs <u>without</u> handrail:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Climb stairs <u>with</u> handrail:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Walk <u>without</u> assistance <u>outdoors</u> greater than 10 steps:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Walk <u>without</u> assistance <u>indoors</u> greater than 10 steps:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Walk <u>with</u> assistance (walker, calipers, AFOs):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
h. Stand <u>without</u> assistance greater than 2 minutes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
i. Stand <u>with</u> assistance (walker, calipers, AFOs):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
j. Stand up from lying down without assistance:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
k. Stand up from a chair without assistance:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
l. Sit when placed:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
m. Lift head while sitting:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
n. Lift head while lying down (head able to clear pillow):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	