

ID: \_\_\_\_\_

## Pediatric Medical, Rehabilitation, and Community Service Questionnaire

### Part A: Types and Intensity of Programs and Services Your Child Receives

*Does your child participate in any of the following community recreational programs – Now or anytime in the past 12 months? (Check all that apply)*

- |   |   |                              |                             |
|---|---|------------------------------|-----------------------------|
| <input type="checkbox"/> Horseback riding         | Is a therapist involved in the program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Aquatics                 | Is a therapist involved in the program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Gym programs             | Is a therapist involved in the program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Dance / movement / music | Is a therapist involved in the program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Sports program           | Is a therapist involved in the program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Other: _____             | Is a therapist involved in the program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

*What type of early intervention or school program does your child currently attend?*

- Does not attend any early intervention school or program
- Participates in an early intervention (birth-three years of age) program  
If yes, what setting? (check all that apply)  
 Home-based       Community child care center       Special center program
- Preschool  
If yes, what type of preschool program? (check all that apply)  
 Community preschool       Special Preschool  
If yes, how many times per week does your child attend preschool? \_\_\_\_\_  
If yes, how many hours per day does your child attend preschool? \_\_\_\_\_
- Elementary School  
If yes, what type of school does your child attend?  
 Neighborhood school       Special School  
If yes, what type of educational program does your child receive? (check all that apply)  
 Standard classroom       Special Classroom

ID: \_\_\_\_\_

***In the past 12 months, has your child receive any services from the following providers?***

***Primary care provider*** (i.e. family doctor, pediatrician or developmental pediatrician)

\_\_\_ Yes      \_\_\_ No

If yes, how many times during the past year has your child seen this person? \_\_\_\_\_

***Early childhood education specialist / special education teacher:*** \_\_\_ Yes      \_\_\_ No

If yes, how many times per month has your child seen this person? \_\_\_\_\_

If less than once per month, then how many times per year? \_\_\_\_\_

On average, how long is each visit with this person? \_\_\_\_\_

Average # of minutes per visit \_\_\_\_\_

***Occupational therapist:*** \_\_\_ Yes      \_\_\_ No

If yes, answer the following questions:

Has your child seen the occupational therapist as *part of an early intervention or school program?* \_\_\_ Yes      \_\_\_ No

If yes, how many times per month has your child seen this person? \_\_\_\_\_

If less than 1 time per month, then how many times per year? \_\_\_\_\_

On average, how long is each visit with this person? \_\_\_\_\_

Average # of minutes per visit \_\_\_\_\_

Has your child seen the occupational therapist at a *hospital clinic, rehabilitation center, or private therapy service?* \_\_\_ Yes      \_\_\_ No

If yes, how many times per month has your child seen this person? \_\_\_\_\_

If less than 1 time per month, then how many times per year? \_\_\_\_\_

On average, how long is each visit with this person? \_\_\_\_\_

Average # of minutes per visit \_\_\_\_\_

ID: \_\_\_\_\_

**Physical therapist:**    \_\_\_ Yes        \_\_\_ No

If yes, answer the following questions:

Has your child seen the physical therapist as part of an early intervention or school program? \_\_\_ Yes    \_\_\_ No

If yes, how many times per month has your child seen this person? \_\_\_\_\_

If less than 1 time per month, then how many times per year? \_\_\_\_\_

On average, how long is each visit with this person? \_\_\_\_\_

Average # of minutes per visit \_\_\_\_\_

Has your child seen the physical therapist at a hospital clinic, rehabilitation center, or private therapy service? \_\_\_ Yes    \_\_\_ No

If yes, how many times per month has your child seen this person? \_\_\_\_\_

If less than 1 time per month, then how many times per year? \_\_\_\_\_

On average, how long is each visit with this person? \_\_\_\_\_

Average # of minutes per visit \_\_\_\_\_

**Speech therapist:** \_\_\_ Yes    \_\_\_ No

If yes, answer the following questions:

Has your child seen the speech therapist as part of an early intervention or school program? \_\_\_ Yes    \_\_\_ No

If yes, how many times per month has your child seen this person? \_\_\_\_\_

If less than 1 time per month, then how many times per year? \_\_\_\_\_

On average, how long is each visit with this person? \_\_\_\_\_

Average # of minutes per visit \_\_\_\_\_

Has your child seen the speech therapist at a hospital clinic, rehabilitation center, or private therapy service? \_\_\_ Yes    \_\_\_ No

If yes, how many times per month has your child seen this person? \_\_\_\_\_

ID: \_\_\_\_\_

If less than 1 time per month, then how many times per year? \_\_\_\_\_

On average, how long is each visit with this person?

Average # of minutes per visit \_\_\_\_\_

**Nutritionist:** \_\_\_ Yes \_\_\_ No

If yes, how many times per year has your child seen the nutritionist? \_\_\_\_\_

**Home health care** (for example home nursing, home health aide, personal care attendant; anyone who helps with bathing, dressing): \_\_\_ Yes \_\_\_ No

If yes, how many times per month has your child seen this person? \_\_\_\_\_

If less than 1 time per month, then how many times per year? \_\_\_\_\_

**Mental health services** (like a child behavioral therapist or a psychologist) \_\_\_ Yes \_\_\_ No

If yes, how many times per month has your child seen this person? \_\_\_\_\_

If less than 1 time per month, then how many times per year? \_\_\_\_\_

**Case manager / care coordinator / service coordinator** \_\_\_\_\_ Yes \_\_\_ No

If yes, how many times per month has your child seen this person? \_\_\_\_\_

If less than 1 time per month, then how many times per year? \_\_\_\_\_

The following services might be offered by individual medical specialists or by health-care teams. *Please note if your child **has received** any of these services **in the past 12 months** and indicate **how often** your child received each service.*

**Developmental Follow-up or Neonatal Intensive Care Unit Follow-up** \_\_\_ Yes \_\_\_ No

If yes: More than once a month [ ] several times per year [ ] once per year or less [ ]

**Neurology** (services by a neurologist for the purposes of diagnosis and / or epilepsy management) \_\_\_\_\_ Yes \_\_\_ No

If yes: More than once a month [ ] several times per year [ ] once per year or less [ ]

**Neuromuscular** (ongoing management services by a doctor of physical medicine and / or team)

ID: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No

If yes: More than once a month [ ] several times per year [ ] once per year or less [ ]

**Orthopedic** (services by an orthopedic surgeon and / or team) \_\_\_ Yes \_\_\_ No

If yes: More than once a month [ ] several times per year [ ] once per year or less [ ]

**Spasticity Management** (such as Botulinum toxin A or baclofen, offered by a physician (such as a pediatrician, neurologist or physical medicine doctor) and / or team) \_\_\_ Yes \_\_\_ No

If yes: More than once a month [ ] several times per year [ ] once per year or less [ ]

**Seating / assistive technology / adaptive equipment** \_\_\_ Yes \_\_\_ No

If yes: More than once a month [ ] several times per year [ ] once per year or less [ ]

**Other Services** (please specify): \_\_\_\_\_ \_\_\_ Yes \_\_\_ No

If yes: More than once a month [ ] several times per year [ ] once per year or less [ ]





ID: \_\_\_\_\_

5a. In the past 12 months, did you have or want community recreation and / or religious activities (play groups, gym / dance / swim sessions, parent and me classes, church activities) for your child?

Yes (answer 5b)                       No (go onto question 6)

5b. To what extent have you received community recreational and / or religious activities that you wanted for your child:

<i>all of the activities</i>	<i>most of the activities</i>	<i>some of the activities</i>	<i>none of the activities</i>
4	3	2	1

Have not looked into what activities are available

6a. In the past 12 months, did you have a need for community support services (respite care, support groups, case management) ?

Yes (answer 6b & 6c)                       No (go onto next section)

6b. To what extent have you received community support services (respite care, support groups, case management) that you and your child needed:

<i>all of the services</i>	<i>most of the services</i>	<i>some of the services</i>	<i>none of the services</i>
4	3	2	1

6c. If you did receive at least some of the services, how long did it take you to receive the services after the request was made:

Less than 3 months                       3 months or longer

ID: \_\_\_\_\_

**Part C: Coordination of Services**

1. How much effort has it taken to coordinate services for your child?

*None at all*      *A little*      *Some*      *A fair amount*      *A lot*  
 5                      4                      3                      2                      1

2. During the past 12 months, how well have the people who provide services to your child and family **WORK WITH YOUR FAMILY** to coordinate a plan of care that will best help your child?

	Not Applicable	Excellent	Good	Fair	Poor	Not at all
Medical personnel (doctors, nurses, therapists at hospitals and outpatient centers, nurses, etc)	NA	5	4	3	2	1
Early Intervention / school personnel (teachers, therapists, service coordinators) with each other	NA	5	4	3	2	1

3. During the past 12 months, how well have the people who provide services to your child and family **WORK TOGETHER WITH EACH OTHER** to coordinate a plan of care that will best help your child?

	Not Applicable	Excellent	Good	Fair	Poor	Not at all
Medical personnel (doctors, nurses, therapists at hospitals and outpatient centers, nurses, etc)	NA	5	4	3	2	1
Early Intervention / school personnel (teachers, therapists, service coordinators) with each other	NA	5	4	3	2	1

ID: \_\_\_\_\_

4. During the past 12 months, how well have the people who provide services to your child and family **WORK TOGETHER WITH EACH OTHER** to coordinate a plan of care that will best help your child?

	Not Applicable	Excellent	Good	Fair	Poor	Not at all
Medical personnel AND early intervention / school personnel	NA	5	4	3	2	1
Medical personnel AND community organizations / agencies (egs. of community organizations / agencies: any activity or service in the community that is not “medical”, like recreation activities, religious groups, support groups)	NA	5	4	3	2	1
Early intervention / school personnel AND community organizations / agencies						

**Part D: Services Meeting Your Needs**

Circle your response for each question.

1. To what extent do all the services you receive meet your child’s and your needs in supporting the development of your child’s motor abilities?

*Completely*    *To a large extent*    *To a fair extent*    *To a small extent*    *Not at all*  
 5                      4                      3                      2                      1

2. To what extent do all the services you receive meet your child’s and your needs in promoting your child’s participation in self-care activities?

*Completely*    *To a large extent*    *To a fair extent*    *To a small extent*    *Not at all*  
 5                      4                      3                      2                      1

3. To what extent do all the services you receive meet your child’s and your needs in promoting your child’s participation in play?

*Completely*    *To a large extent*    *To a fair extent*    *To a small extent*    *Not at all*

ID: \_\_\_\_\_

5

4

3

2

1

ID: \_\_\_\_\_

**Part E: Focus of Therapy Services**

1. Think of your child’s physical and occupational therapy sessions during the past year. Think about the therapists who routinely see your child. Please rate the extent to which the physical and / or occupational therapists provided these interventions. Circle your response for each statement.

	To a very great extent	To a great extent	To a moderate extent	To a small extent	Not at all	Do not know / not sure
<u>Relaxation of muscles</u> (gently moving, rocking, massaging, etc)	5	4	3	2	1	0
<u>Balance activities</u> (practice with your child holding different positions, responding to a bump or tilt, or reaching and regaining balance, etc)	5	4	3	2	1	0
<u>Physically guiding your child’s way of moving during any motor activities</u> (therapist’s hands on your child to guide movements)	5	4	3	2	1	0
<u>Stretching exercises</u> (moving or positioning your child’s limbs to stretch tight muscles)	5	4	3	2	1	0
<u>Strengthening exercises</u> (muscle activity against a resistance such as lifting heavy toys, riding a tricycle with weights, use of ankle or wrist weights, etc.)	5	4	3	2	1	0
<u>Endurance exercises</u> (activities which require movement for a sustained period of time such as long walks, bike rides, active games)	5	4	3	2	1	0
<u>Transfer training</u> (moving from one position to another, transferring from one surface to another)	5	4	3	2	1	0
<u>Mobility training</u> (movement through the environment via crawling, walking, use of crutches / walker,	5	4	3	2	1	0

ID: \_\_\_\_\_

use of a wheelchair, etc)	To a very great extent	To a great extent	To a moderate extent	To a small extent	Not at all	Do not know / not sure
<u>Practice of specific tasks</u> (such as opening a door, putting toys away, doing some motor activity of your or your child's choice, etc.)	5	4	3	2	1	0
<u>Assistive devices and/or equipment training</u> (measuring, fitting, adjusting, and use of braces, switch activation of toys, special chairs, standers, bathroom devices, etc.)	5	4	3	2	1	0
<u>Adaptations / modifications for the home, classroom, or child care setting</u> (size and location of furniture, ramps, use of visual and auditory cues, etc.)	5	4	3	2	1	0
<u>Self-care routines</u> (dressing, bathing, feeding, hygiene)	5	4	3	2	1	0
<u>Structured play activities</u> (focus on play and interaction with toys & people)	5	4	3	2	1	0

2. Please share with us other types of specific interventions that your child participates in or the therapist does that we have not listed:

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ID: \_\_\_\_\_

3. Think about the FOCUS OF YOUR CHILD’S THERAPY sessions IN THE PAST YEAR. What did your child’s therapists concentrated on the most during the therapy sessions – for example was it stretching and strengthening, or was it helping with learning to get dressed?

PLEASE READ THE 5 DESCRIPTIONS BELOW about different therapies.

Mark those descriptions in the right order for your child- from the most focus (#5) to the least focus (#1)– and remember to think about the past year only.

Interventions that focus on relaxation of muscles, balance, and physically guiding movements \_\_\_\_\_

Interventions that focus on stretching, strengthening, and endurance \_\_\_\_\_

Interventions that focus on transfers, mobility, and practice of motor tasks \_\_\_\_\_

Interventions that focus on adaptive equipment and modifications to the environment \_\_\_\_\_

Interventions that focus on self-care activities \_\_\_\_\_

Interventions that focus on play activities \_\_\_\_\_

ID: \_\_\_\_\_

4. Please rate the extent to which your therapists do the following items. Circle your response for each statement.

	To a very great extent	To a great extent	To a moderate extent	To a small extent	Not at all
Talk with you to obtain information on your family routines (what you like to do and what works well for you).	5	4	3	2	1
Involves the child and family in deciding what activities to do or what will be the focus of your child's therapy visits.	5	4	3	2	1
Have discussions with your family to share information, resources, and suggestions, including asking you for your input.	5	4	3	2	1
Supply information about resources for you and your child in various different ways, like books, worksheets, pictures, videotapes, websites, etc).	5	4	3	2	1
Assist you in finding and setting up community resources to meet your child and family needs.	5	4	3	2	1
Provide you with plans and recommendations about activities that you can use during your daily routines to support your child and family.	5	4	3	2	1
Participate in visits together with other team members to coordinate plans to support your child and family.	5	4	3	2	1
Plan therapy that fits into your child's daily routines and activities to support your child's function and participation in the home, school, and community.	5	4	3	2	1
Uses your child's own toys and household /child care / school items during therapy activities.	5	4	3	2	1
Provide therapy in community settings such as the park, store, playground, restaurant, or community center.	5	4	3	2	1

ID: \_\_\_\_\_

Interact with your child at his / her level and involve him / her in activities during therapy visits.	5	4	3	2	1
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5. Please rate the extent you are able to do the following items. Circle your response for each item.

	To a very great extent	To a great extent	To a moderate extent	To a small extent	Not at all
Include therapy recommendations into my child's daily routines and activities.	5	4	3	2	1
Work together with the therapists and my child in activities during therapy visits.	5	4	3	2	1

6. Please rate your child's relationship with the therapists.

*Very positive*      *Positive*      *Neutral*      *Negative*      *Very negative*  
 5                      4                      3                      2                      1

7. Please rate your relationship with your child's therapists.

*Very positive*      *Positive*      *Neutral*      *Negative*      *Very negative*  
 5                      4                      3                      2                      1

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ID: \_\_\_\_\_

therapy and occupational therapy for young children with cerebral palsy. *Physical and Occupational Therapy for Children*, 32(4):368–382. Research on this measure was supported by the Canadian Institutes of Health Research (MOP 81107) and the US Department of Education, National Institutes of Disability and Rehabilitation Research (H133G060254).