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)

___ Horsecback riding Is a therapist involved in the program? ___ Yes ___ No
___ Aquatics Is a therapist involved in the program? ___ Yes ___ No
___ Gym programs Is a therapist involved in the program? ___ Yes ___ No
___ Dance / movement / music Is a therapist involved in the program? ___ Yes ___ No
___ Sports program Is a therapist involved in the program? ___ Yes ___ No
___ Other: ___________________ Is a therapist involved in the program? ___ Yes ___ 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
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 _____
**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 you 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 [ ]
Part B: Availability and Access of Services

Check or circle your response to each question.

1a. In the past 12 months, did your child have medical needs (pediatrician, specialists, therapy, and clinic follow-up) other than primary health care typical for all children? Primary health care includes a doctor or health care professional seeing your child when he or she is sick with a cold or flu, or needs an immunization shot.
   ___ Yes (answer 1b & 1c)   ___ No (go onto question 2)

1b. To what extent have you received the medical services that your child needed:
   all of the services  most of the services  some of the services  none of the services
   4                  3                  2                  1

1c. If you did receive at least some of the services, how long did it take to receive the services after the request was made:
   ___ Less than 6 months   ___ 6 months or longer

2a. In the past 12 months, did your child have mental health needs (such as behavioral therapy, counseling, or a visit to a psychologist)?
   ___ Yes (answer 2b & 2c)   ___ No (go onto question 3)

2b. To what extent have you received the mental health services that your child needed:
   all of the services  most of the services  some of the services  none of the services
   4                  3                  2                  1

2c. If you did receive at least some of the services, how long did it take to receive the services after the request was made:
   ___ Less than 6 months   ___ 6 months or longer

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3a. In the past 12 months, did your child have needs for developmental or pre-school educational services through an early intervention system, an infant development program, an infant-parent program, or a school program?
   ___ Yes (answer 3b & 3c)       ___ No (go onto question 4)

3b. To what extent have you received developmental or pre-school educational services that your child needed:
   
   all of the services   most of the services   some of the services   none of the services
   4                   3                   2                   1

3c. If you did receive at least some of the services, how long did it take to receive the services after the request was made:
   ___ Less than 6 months       ___ 6 months or longer

4a. In the past 12 months, did your child have needs for therapy services (physical, occupational, or speech therapy) through the early intervention system, an infant development program, an infant-parent program, or a school program?
   ___ Yes (answer 4b & 4c)       ___ No (go onto question 5)

4b. To what extent have you received therapy services through the early intervention system that your child needed:
   
   all of the services   most of the services   some of the services   none of the services
   4                   3                   2                   1

4c. If you did receive at least some of the services, how long did it take to receive the services after the request was made:
   ___ Less than 6 months       ___ 6 months or longer
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:

<table>
<thead>
<tr>
<th>all of the activities</th>
<th>most of the activities</th>
<th>some of the activities</th>
<th>none of the activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

___ 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:

<table>
<thead>
<tr>
<th>all of the services</th>
<th>most of the services</th>
<th>some of the services</th>
<th>none of the services</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

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
Part C: Coordination of Services

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

<table>
<thead>
<tr>
<th>None at all</th>
<th>A little</th>
<th>Some</th>
<th>A fair amount</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

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?

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

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?

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

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Not Applicable</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical personnel AND early intervention / school personnel</td>
<td>NA</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Medical personnel AND community organizations / agencies</td>
<td>NA</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Medical personnel AND early intervention / school personnel (like recreation</td>
<td>NA</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>activities, religious groups, support groups)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early intervention / school personnel AND community organizations / agencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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?

   
   
   Complete    | 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?

   
   
   Complete    | 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?

   
   
   Complete    | To a large extent    | To a fair extent    | To a small extent    | Not at all
   5           | 4                     | 3                    | 2                     | 1
Amount and Focus of Physical Therapy and Occupational Therapy for Young Children with Cerebral Palsy. *Physical and Occupational Therapy in Pediatrics.* 2012; 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 (H133G080254).
### 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.

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

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

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

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

<table>
<thead>
<tr>
<th>Item</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interact with your child at his / her level and involve him / her in activities during therapy visits.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Include therapy recommendations into my child's daily routines and activities.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Work together with the therapists and my child in activities during therapy visits.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Rating</th>
<th>5</th>
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7. Please rate your relationship with your child’s therapists.

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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).