

SMART Walker™ Orthosis

Suitability Questionnaire

DATE	CHILD'S NAME	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
CHILD'S DATE OF BIRTH	CHILD'S HEIGHT	CHILD'S WEIGHT	
PRIMARY DIAGNOSIS (e.g. CP)		SECONDARY DIAGNOSIS (e.g. seizures)	
NAME OF MOTHER/GUARDIAN		NAME OF FATHER/GUARDIAN	
STREET ADDRESS		CITY	
PROVINCE/STATE	POSTAL CODE/ZIP	COUNTRY	
HOME PHONE NUMBER	PARENT BUSINESS NUMBER	PARENT CELL NUMBER	
PRIMARY PHYSICIAN NAME	PHONE NUMBER	ADDRESS	
Is your child able to take steps when partially supported by an adult? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Does your child wear splints/AFOs? YES <input type="checkbox"/> NO <input type="checkbox"/>			
If YES, where did they receive these? _____			
Does your child use a walking device at this time (e.g. walker, crutches) or have they tried some type of walker before?			
YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please describe: _____			

Is your child able to walk while using these devices? YES <input type="checkbox"/> NO <input type="checkbox"/>			
If YES, please check: Independently <input type="checkbox"/> With Assistance <input type="checkbox"/> At Home <input type="checkbox"/> At School <input type="checkbox"/> In Community <input type="checkbox"/>			
In your opinion, which of the following limits your child's walking ability? (check all that apply)			
Fear <input type="checkbox"/> Pain <input type="checkbox"/> Weakness <input type="checkbox"/> Endurance <input type="checkbox"/> Stiffness <input type="checkbox"/> Coordination <input type="checkbox"/> Vision <input type="checkbox"/> Comprehension <input type="checkbox"/>			

(over)

Does your child use a wheelchair? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, is it Manual <input type="checkbox"/> Powered <input type="checkbox"/>
Does your child receive therapy? YES <input type="checkbox"/> NO <input type="checkbox"/> (if NO, skip to the next section) If YES, where is it done? (home, school, treatment centre) _____ How often is the therapy done? _____ NAME OF P.T. _____ TEL _____ AFFILIATION _____ NAME OF O.T. _____ TEL _____ AFFILIATION _____
Does your child attend school? YES <input type="checkbox"/> NO <input type="checkbox"/> (if NO, skip to the next section) If YES, which school/where is it? _____ Does your child have pupil assistants? YES <input type="checkbox"/> NO <input type="checkbox"/>
Does your child have a special needs assistant at home? YES <input type="checkbox"/> NO <input type="checkbox"/>
What are your expectations of your child's abilities with the proposed SMART Walker? _____ _____ _____ _____ _____
If your child was found suitable to receive a walker, where do you anticipate the walker would be used the most? At home <input type="checkbox"/> At school <input type="checkbox"/> In the community <input type="checkbox"/>
Would your home be accessible to such a device? YES <input type="checkbox"/> NO <input type="checkbox"/>

PLEASE MAIL, FAX OR E-MAIL YOUR COMPLETED QUESTIONNAIRE TO:

