Children's Hospital Colorado

Movement Questionnaire

General Information:

Patient Name: _____

Date of Birth: _____

Current Age: _____

Gender: _____

Description of Abnormal Movements:

Please describe the abnormal movement(s) and body part(s) involved:

_____

_____

_____

_____

How old was your child when it started? _____

Were any medications stopped or started in the 6 months prior to this movement developing? Yes ☐ No ☐
If answered yes above, what medication(s) and how long before?

_____

_____

_____

_____

Has it gotten worse, better, or changed at all since it started?

_____

_____

What makes it worse?

_____

_____

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What makes it better?

Is your child ever able to stop the movement if distracted, picked up, or asked?

Are there any triggers for it (activities like writing, eating, walking, or emotions like anxiety or anger, etc) or specific body positions in which it will occur (only while seated)?

Is it interfering with your child's ability to do anything, and if so, how?

Is there anyone else in the family with similar movements? If so, who?

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Interventions:

For each intervention please list date(s) of intervention, and effect on abnormal movements.

Past Medications

Medication	Dates of Use	Maximum Dose	Effect	Side Effects	Discontinued Reason

Therapy (PT/OT/Speech): Yes ☐ No ☐
If answered yes, please provide the following information: Starting when? How frequently? Was/is it effective?

Botulinum Toxin Injections: Yes ☐ No ☐
If answered yes, please provide the following information: Dates of injection; Injection Sites; was it effective?

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Phenol Injections: Yes ☐ No ☐
If answered yes, please provide the following information: Dates of injection; Injection Sites; was it effective?

_____

_____

_____

_____

Past Surgeries: (If your child has had one of the following surgeries listed below, please list approximate date of surgery)

- Tendon releases or transfers: _____
- Rhizotomy: _____
- Baclofen Pump: _____
- Other: _____

Equipment: (What your child has used and approximate dates of use for each)

- Orthotics: _____
- Cane: _____
- Crutches: _____
- Walker (type): _____
- Wheelchair (manual or power): _____

Please feel free to list any additional information below:

_____

_____

_____

_____

_____

_____

_____

_____

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*Thank you for completing the following questionnaire. Please send this questionnaire, along with the other items included in the new patient packet by one of the following methods:

Mail:	Scan In and Email:	Fax:	MyChart:
Children's Hospital Colorado Neurology Department; Attention: Complex Movement Coordinator 13123 East 16th Avenue, B-155 Aurora, CO 80045	neurologynursing@childrenscolorado.org ***Please put Attention: Complex Movement Coordinator in the subject line***	(720) 777-7196 Attention: Neurology Box-155, Complex Movement Coordinator	Attach the questionnaire to a MyChart message to Complex Movement provider, Dr. Abigail Collins. ***Please put Attention: Complex Movement Coordinator in the subject line***

Sincerely,

The Complex Movement Team

Neuroscience Institute
Children's Hospital Colorado
13123 East 16th Avenue, B-155
Aurora, CO 80045
Phone: (720) 777-6895
Fax: (720) 777-7196