Cerebral Palsy Practice Analysis Form

PT Code:___ **Patient Code**:___ **Gender**: ☐M ☐F **Age**: ___yr ___mo **Setting**: ☐Inpt ☐Outpt ☐ School ☐ EI ☐ Home ☐ Other _____

Diagnostic Information

GMFCS Level
- ☐ Level 1
- ☐ Level 2
- ☐ Level 3
- ☐ Level 4
- ☐ Level 5

Level of Involvement
- ☐ Quadriplegia
- ☐ Diplegia
- ☐ Hemiplegia
- ☐ Triplegia
- ☐ Other _____

Type of CP
- ☐ Spastic
- ☐ Athetoid
- ☐ Hypotonic
- ☐ Other _____

Orthotic Device

R	L	
☐	☐	KAFO
☐	☐	AFO
☐	☐	SMO

- ☐ Other _____
- ☐ None

Primary Assistive Device

H	C	
☐	☐	Strider (Forward) Walker
☐	☐	Postural (Rear) Walker
☐	☐	Forearm Crutches
☐	☐	Axillary Crutches
☐	☐	Cane
☐	☐	Wheelchair
☐	☐	Other _____
☐	☐	None

Medications
- ☐ Tone
- ☐ Seizures
- ☐ Other _____
- ☐ None

	INTERVENTIONS											
	W-1	W-2	W-3	W-4	W-5	W-6	W-7	W-8	W-9	W-10	W-11	W-12
Rx-1												
Rx-2												
Rx-3												
Rx-4												

General
1. Stretching/ROM
2. Strengthening
3. Biofeedback
4. Electrical Stimulation
5. Aquatic Therapy
6. Sensory Integration

Ambulation
7. General Gait Training
8. PBWS Walking
9. Aquatic Gait Training
10. Stair Climbing
11. Running/Jumping/Hopping
12. Wheelchair Skills

Balance
13. Anticipatory Balance
14. Reactive Balance

Gross Motor
15. Transitional Skills
16. Transfer Training

Education
17. Patient/Family Education
18. Home Program
19. Classroom Consultation

Other (specify)
20.

Date of First Visit: _____ Date of Last Visit: _____ Number of visits within course of care recorded: _____

Is the initial visit actually the patient's first visit? Yes / No If not, what was the date of the patient's first visit? _____

How many times has the patient been seen by a physical therapist during this episode of care? _____

Is the final visit entered the actual discharge visit? Yes / No