1. Does the participant/subject use mobility devices?  Yes (complete section 1)  No
2. Does the participant/subject use orthoses?  Yes (complete section 2)  No
3. Besides use of mobility devices, orthoses, and positioning devices, does the participant/ subject utilize other therapies?  Yes, specify: (complete section 3)  No

Table to Record Usages of Mobility Devices

| Name of Device | Device Used? |
| --- | --- |
| Section 1. Mobility Devices | N/A |
| Manual wheelchair | Yes: Full-time use Part-time use  No  Not Applicable |
| Power wheelchair | Yes: Full-time use Part-time use  No  Not Applicable |
| Power assist wheelchair | Yes:   1. Full-time use Part-time use 2. Is the wheelchair driven by the participant/subject?  Yes  No   No  Not Applicable |
| Other mobility device | Yes  Scooter  Stroller  Standers  Other specify: (check all that apply)  No  Not Applicable |
| Positioning in wheelchair | Regular/daily tilt:  Yes  No  Not applicable  Supported standing use:  Yes  No  Not Applicable |
| Upper extremity devices | Yes specify:  No  Not Applicable |
| Section 2. Orthoses and Positioning Devices | N/A |
| Inserts of any type | Yes  No  Not Applicable |
| Supramalleolar orthotic (SMO) | Yes  No  Not Applicable |
| Ankle-foot orthosis (AFO) | Yes:   1. Type:  Solid  Articulating  DAFO 2. Use:  Walking  Resting splints (choose all that apply)   No  Not Applicable |
| Knee-ankle-foot orthosis (KAFO) | Yes, ischial weight bearing?  Yes  No  No  Not Applicable |
| Hip-knee-ankle foot orthosis (HKAFO) | Yes  No  Not Applicable |
| Stander | Yes  No  Not Applicable |
| Body jacket/ Thoracic-lumbar-sacral orthoses (TLSO) | Yes  No  Not Applicable |
| Reciprocal gait orthoses (RGO) | Yes  No  Not Applicable |
| Other Orthoses | Other specify: |

Section 3: Other Treatments

| Type of Therapy | Use of therapy (If yes, complete frequency and duration) | Frequency | Duration |
| --- | --- | --- | --- |
| Hydrotherapy (aqua therapy) | Yes  No | Days/week: | 15 minutes  30 minutes  45 minutes  60 minutes  Other, specify: |
| Recreational activities/Active exercise | Yes, specify:  No | Days/week: | 15 minutes  30 minutes  45 minutes  60 minutes  Other, specify: |
| Hippotherapy (therapeutic horseback riding) | Yes  No | Days/week: | 15 minutes  30 minutes  45 minutes  60 minutes  Other, specify: |
| Other type of activity | Yes, specify:  No | Days/week: | 15 minutes  30 minutes  45 minutes  60 minutes  Other, specify: |
| Serial casting | Yes  No | Days/week: | 15 minutes  30 minutes  45 minutes  60 minutes  Other, specify: |

## General Instructions

Information on the external devices used by the participant.

## Specific Instructions

Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.