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 applicableSupported 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.