

**KEMENTERIAN KESIHATAN MALAYSIA
PHYSIOTHERAPY DEPARTMENT
PAEDIATRICS NEUROLOGY ASSESSMENT FORM**

Name: ----- Age: ----- Sex: M / F RN / IC: ----- Date: -----

DIAGNOSIS	CURRENT HISTORY
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DOCTOR'S MANAGEMENT	
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PROBLEM	PAST HISTORY
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PAIN SCORE	Pre	
	Post	

SPECIAL QUESTION	OBSERVATION / PALPATION
General Health :	Basic Tone :
PMHx / Surgery :	Tone reaction to stimulus:
Investigations: :	Local observation:
Medication :	Vocalization :
Home/ Social Situation :	Hearing :
Family history :	Vision :
Pacemaker/ Hearing Aid: Y / N	Contracture and Deformity :

FUNCTIONAL ACTIVITIES	
Dressing :	Emotional and Mental Status :
Toileting :	Sensation :
Gait / Ambulation :	Stereognosis :
	Position and movement sense :

POSTURE AND MOVEMENT

Grading: Good (G) Fair (F) Poor (P) Nil (N)

SUPINE:	
Rolling	
Crook Lying and Bridging	
Pulled to Sitting (head Control)	
Sitting	
PRONE:	
Head control	
Extended Arm support	
Reaching out	
Progress along floor	
To prone kneeling	
To sitting	
SITTING:	
Long Sitting	
Side sitting	
Sitting to standing	
PRONE KNEELING:	
Crawling	
Reaching out	
To upright kneeling	
To half kneeling	
Walking on knee	
To standing	
STANDING:	
Weight transference	
Stride standing	
Walk standing	
Step standing	

ORAL FUNCTION

Sucking Reflex	
Swallowing	
Feeding	

HAND FUNCTION	Right	Left
Tonic reaction of finger flexors		
Approach to object		
Manipulation of: Large object Small object		
Use of hand in midline		
Type of grasp:		
Transfer hand to hand		

GMFCS Score : _____
MAS Score : _____

REFLEXES (√ if present)	
Neck righting	
Landau	
Parachute reaction	
Tonic neck	
Amphibian	
Moro	
Placing	
Equilibrium	

RANGE OF MOTION		
	RIGHT	LEFT
UPPER LIMB		
LOWER LIMB		

PHYSIOTHERAPIST'S IMPRESSION

SHORT TERM GOALS

LONG TERM GOALS

PLAN OF TREATMENT

Attending Physiotherapist:.....

Date :

Sign & stamp

KEMENTERIAN KESIHATAN MALAYSIA GUIDELINES FOR THE USE OF PAEDIATRICS NEUROLOGY ASSESSMENT FORM

DIAGNOSIS

- As in referral.

DOCTOR'S MANAGEMENT

- Brief conservative or operative management

PROBLEM

- What is the presenting problem?

PAIN SCORE

- Pre and post scores
- Level of pain as indicated by patient (Whichever is applicable based on MOH Pain scales) i.e. faces scale or FLACC scale.

SPECIAL QUESTION

General Health

- General unwell - indicates possible Systemic problem

Past Medical History/Surgery

- Other medical illness
- Include mother's obstetric history.

Investigation

- X-ray, CT scan, MRI, Blood Test if relevant
- Date taken.

Medication

- Drugs used especially:
 - Anti Fits e.g. Epillin / Luminal,
 - Anti-Spasticity e.g. Baclofen
 - For Recurrent Lung infections
- Side Effects: Short term/Long term

Home/Social Situation

- Number in family/number of siblings
- Parents/ carers financial status
- Type of accommodation/house

Family History

- e.g.: Hereditary disease.

Pacemaker/ Hearing Aid

- If relevant

SKALA KESAKITAN KANAK-KANAK (3-7 TAHUN)



SKALA KESAKITAN DEWASA (>7 TAHUN)



SKALA FLACC (>1 BULAN -3 TAHUN / IMPAIRMENT)

KATEGORI	PEMARKAHAN		
	0	1	2
WAJAH	TIADA EKSPRESI TERTENTU DI WAJAH ATAU DALAM KEADAAN TERSENYUM	KADANG TERLIHAT MUKA BERKERUT, MURUNG, TIDAK BERMAYA ATAU TIDAK BERSEMANGAT	RAHANG TERKANCING, DAGU BERGETAR (PADA KADAR KERAP HINGGA BERTERUSAN)
KAKI	KEDUDUKAN BIASA ATAU SELESA	KEADAAN TIDAK SELESA, RESAH ATAU TEGANG	MENENDANG-NENDANG ATAU MEMBENGKOKKAN KAKI
AKTIVITI	BERBARING TENANG, BERKEDUDUKAN BIASA, BERGERAK DENGAN SELESA	BERGULING, BERGANJAK DEPAN DAN BELAKANG, TEGANG	MERINGKUK KAKU ATAU MENGGELUPUR
TANGIS	TIDAK MENANGIS (KEADAAN TIDUR ATAU TERJAGA)	MIRENGEK DAN KADANG MENGELUH	MENANGIS BERTERUSAN, BERTERIAK DAN TERESA-ESAK, SERING MENGELUH
KEBOLEH PUJUKAN	TENANG	MASIH DAPAT DIPUJUK DENGAN SESEKALI SENTULHAN, PELUKAN ATAU KATA-KATA SEHINGGA MUDAH TERGANGGU	SUKAR DIPUJUK

SETIAP KATEGORI DIBERI NAIK KAH 0-2 DENGAN JUMLAH KESELURUHAN 0-10

FUNCTIONAL ACTIVITIES

Ability in doing functional activities such as dressing, toileting and gait / ambulation.

Assess the following task:

- Dressing
- Toileting
- Mobility

CURRENT HISTORY

- Details and mode of onset, symptoms, course of condition

PAST HISTORY

- Existing pathology with bearing on current condition.
- Previous physiotherapy treatment? Result?

OBSERVATION / PALPATION

- Basic Tone
 - State the present muscle tone e.g.: hypertone, hypotone.
- Tone and Reaction to Stimulation:
- Local Observation
 - Need to observe many angles e.g.: foot/hand (other than CP)
 - Specific task for functional activity: Creep / crawl / aids / orthosis
 - Posture
- Vocalization / Speech
- Hearing
- Vision
- Contracture and Deformity
- Emotional and Mental state
- Sensation
- Stereognosis
- Position and movement sense

Observation of Posture and Movement

Observe the posture and movement and grade as follows:

Good (G) Fair (F) Poor (P) Nil (N)

Oral Function

Grade as follows:

Good (G) Fair (F) Poor (P) Nil (N)

Hand function

Grade as follows:

Good (G) Fair (F) Poor (P) Nil (N)

Reflexes

Test the following reflexes:

- Neck righting Reaction
- Amphibian Reaction
- Landau reflex
- Moro Reflex
- Parachute Reactions
- Placing Reactions
- Tonic Reflexes
- Equilibrium Reactions

Outcome Measure

GMFCS score : _____ (refer appendix II)

MAS score : _____ (refer appendix III)

Range of Motion

Measure the affected limb

PHYSIOTHERAPIST'S IMPRESSION

- Note the problem according to priority with regards to physiotherapy

SHORT TERM GOALS

- With respect to specific aspects set according to priority

LONG TERM GOALS

- With realistic approach to prognosis

TREATMENT PLAN

- Treatment according to goals set

SIGN/ STAMP / DATE

- Need to be filled by attending physiotherapist

References

1. The P5VS Guidelines (2nd edition, 2013)

THE MODIFIED ASHWORTH SCALE (MAS)

GRADE	DESCRIPTION
0	No increase in muscle tone
1	Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end range of the ROM when the affected part(s) is moved in flexion or extension.
1 +	Slight increase in muscle tone, manifested by a catch, followed by minimal resistance throughout the remainder of the ROM.
2	More marked increase in muscle tone through most of the ROM, but affected part(s) easily moved.
3	Considerable increase in muscle tone; passive movement difficult.
4	Affected part(s) rigid in flexion or extension.

GROSS MOTOR FUNCTION CLASSIFICATION SYSTEM FOR CEREBRAL PALSY (GMFCS)

BEFORE 2ND BIRTHDAY	
Level I	Infants move in and out of sitting and floor sit with both hands free to manipulate objects. Infants crawl on hands and knees, pull to stand and take steps holding on to furniture. Infants walk between 18 months and 2 years of age without the need for any assistive mobility device.
Level II	Infants maintain floor sitting but may need to use their hands for support to maintain balance. Infants creep on their stomach or crawl on hands and knees. Infants may pull to stand and take steps holding on to furniture.
Level III	Infants maintain floor sitting when the low back is supported. Infants roll and creep forward on their stomachs.
Level IV	Infants have head control but trunk support is required for floor sitting. Infants can roll to supine and may roll to prone.
Level V	Physical impairments limit voluntary control of movement. Infants are unable to maintain antigravity head and trunk postures in prone and sitting. Infants require adult assistance to roll.
BETWEEN 2ND AND 4TH BIRTHDAY	
Level I	Children floor sit with both hands free to manipulate objects. Movements in and out of floor sitting and standing are performed without adult assistance. Children walk as the preferred method of mobility without the need for any assistive mobility device.
Level II	Children floor sit but may have difficulty with balance when both hands are free to manipulate objects. Movements in and out of sitting are performed without adult assistance. Children pull to stand on a stable surface. Children crawl on hands and knees with a reciprocal pattern, cruise holding onto furniture and walk using an assistive mobility device as preferred methods of mobility.
Level III	Children maintain floor sitting often by "W-sitting" (sitting between flexed and internally rotated hips and knees) and may require adult assistance to assume sitting. Children creep on their stomach or crawl on hands and knees (often without reciprocal leg movements) as their primary methods of self-mobility. Children may pull to stand on a stable surface and cruise short distances. Children may walk short distances indoors using an assistive mobility device and adult assistance for steering and turning.
Level IV	Children floor sit when placed, but are unable to maintain alignment and balance without use of their hands for support. Children frequently require adaptive equipment for sitting and standing. Self-mobility for short distances (within a room) is achieved through rolling, creeping on stomach, or crawling on hands and knees without reciprocal leg movement.
Level V	Physical impairments restrict voluntary control of movement and the ability to maintain antigravity head and trunk postures. All areas of motor function are limited. Functional limitations in sitting and standing are not fully compensated for through the use of adaptive equipment and assistive technology. At Level V, children have no means of independent mobility and are transported. Some children achieve self-mobility using a power wheelchair with extensive adaptations.
BETWEEN 4TH AND 6TH BIRTHDAY	
Level I	Children get into and out of, and sit in, a chair without the need for hand support. Children move from the floor and from chair sitting to standing without the need for objects for support. Children walk indoors and outdoors, and climb stairs. Emerging ability to run and jump.

Level II	Children sit in a chair with both hands free to manipulate objects. Children move from the floor to standing and from chair sitting to standing but often require a stable surface to push or pull up on with their arms. Children walk without the need for any assistive mobility device indoors and for short distances on level surfaces outdoors. Children climb stairs holding onto a railing but are unable to run or jump.
Level III	Children sit on a regular chair but may require pelvic or trunk support to maximize hand function. Children move in and out of chair sitting using a stable surface to push on or pull up with their arms. Children walk with an assistive mobility device on level surfaces and climb stairs with assistance from an adult. Children frequently are transported when travelling for long distances or outdoors on uneven terrain.
Level IV	Children sit on a chair but need adaptive seating for trunk control and to maximize hand function. Children move in and out of chair sitting with assistance from an adult or a stable surface to push or pull up on with their arms. Children may at best walk short distances with a walker and adult supervision but have difficulty turning and main training balance on uneven surfaces. Children are transported in the community. Children may achieve self-mobility using a power wheelchair.
Level V	Physical impairments restrict voluntary control of movement and the ability to maintain antigravity head and trunk postures. All areas of motor function are limited. Functional limitations in sitting and standing are not fully compensated for through the use of adaptive equipment and assistive technology. At Level V, children have no means of independent mobility and are transported. Some children achieve self-mobility using a power wheelchair with extensive adaptations.
BETWEEN 6TH AND 12TH BIRTHDAY	
Level I	Children walk indoors and outdoors, and climb stairs without limitations. Children perform gross motor skills including running and jumping but speed, balance, and coordination are reduced.
Level II	Children walk indoors and outdoors, and climb stairs holding onto a railing but experience limitations walking on uneven surfaces and inclines, and walking in crowds or confined spaces. Children have at best only minimal ability to perform gross motor skills such as running and jumping.
Level III	Children walk indoors or outdoors on level surface with an assistive mobility device. Children may climb stairs holding onto a railing. Depending on upper limb function, children propel a wheelchair manually or are transported when travelling for long distances or outdoors on uneven terrain.
Level IV	Children may maintain levels of function achieved before age 6 or rely more on wheeled mobility at home, school, and in the community. Children may achieve self-mobility using a power wheelchair.
Level V	Physical impairments restrict voluntary control of movement and the ability to maintain antigravity head and trunk postures. All areas of motor function are limited. Functional limitations in sitting and standing are not fully compensated for through the use of adaptive equipment and assistive technology. At level V, children have no means of independent mobility and are transported. Some children achieve self-mobility using a power wheelchair with extensive adaptations.

DISTINCTIONS BETWEEN LEVELS I AND II

Compared with children in Level I, children in Level II have limitations in the ease of performing movement transitions; walking outdoors and in the community; the need for assistive mobility devices when beginning to walk; quality of movement; and the ability to perform gross motor skills such as running and jumping.

DISTINCTIONS BETWEEN LEVELS II AND III

Differences are seen in the degree of achievement of functional mobility. Children in Level III need assistive mobility devices and frequently orthoses to walk, while children in Level II do not require assistive mobility devices after age 4.

DISTINCTIONS BETWEEN LEVEL III AND IV

Differences in sitting ability and mobility exist, even allowing for extensive use of assistive technology. Children in Level III sit independently, have independent floor mobility, and walk with assistive mobility devices. Children in Level IV function in sitting (usually supported) but independent mobility is very limited. Children in Level IV are more likely to be transported or use power mobility.

DISTINCTIONS BETWEEN LEVELS IV AND V

Children in Level V lack independence even in basic antigravity postural control. Self-mobility is achieved only if the child can learn how to operate an electrically powered wheelchair.