Parent/Caregiver's Name: _____

Relationship to Child: _____

Date of Completion (dd/mm/yyyy): _____ / _____ /_____

Completed by Research Team

REB #: _____ **Study ID:** _____

Event: ❍ Baseline ❍ Post-Op Month #: _____

Gait Outcomes Assessment List (GOAL™) Questionnaire

Parent Version

1. We want to know about your child's walking and mobility.
2. Please answer <u>all</u> questions by circling the number that fits best.
3. You may choose to add more items that are important to you at the end of the questionnaire.

For example:

A) Activities of Daily Living & Independence								**LEVEL OF ASSISTANCE**				**IS THIS <u>YOUR GOAL</u> TO IMPROVE?**		
Consider how your child **<u>usually</u>** performs each of the following activities. 1) Rate how **easy or difficult** it was for your child to perform each of these activities in the **<u>past 4 weeks</u>**; **AND** 2) Choose how much **assistance** your child required to help them perform these activities; **AND** 3) Select **how important a goal** it is for you to have your child improve in each of the following activities.														
During the <u>past 4 weeks</u>:	***Extremely Difficult / Impossible***	***Very Difficult***	***Difficult***	***Slightly Difficult***	***Easy***	***Very Easy***	***No problem at all***	**TOTAL**	**MODERATE**	**MINIMAL / SUPERVISED**	**INDEPENDENT**	**NOT A GOAL**	**SOMEWHAT IMPORTANT**	**VERY IMPORTANT**
1. Getting in and out of bed	0	1	2	3	4	(5)	6	0	(1)	2	3	0	1	(2)

In the above example, **getting in and out of bed** was rated as ***very easy;***
required a ***moderate level of assistance;*** and improving this was a ***very important*** goal.

A) Activities of Daily Living & Independence

Consider how your child **usually** performs each of the following activities.

1) Rate how **easy or difficult** it was for your child to perform each of these activities in the **past 4 weeks**; **AND**
2) Choose how much **assistance** your child required to help them perform these activities; **AND**
3) Select **how important a goal** it is for you to have your child **improve** in each of the following activities.

During the past 4 weeks:	*Extremely Difficult / Impossible*	*Very Difficult*	*Difficult*	*Slightly Difficult*	*Easy*	*Very Easy*	*No problem at all*	LEVEL of ASSISTANCE: TOTAL	MODERATE	MINIMAL / SUPERVISED	INDEPENDENT	IS THIS YOUR GOAL TO IMPROVE? NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
1. Getting in and out of bed	0	1	2	3	4	5	6	0	1	2	3	0	1	2
2. Getting in and out of a chair (or wheelchair)	0	1	2	3	4	5	6	0	1	2	3	0	1	2
3. Standing at a sink or counter	0	1	2	3	4	5	6	0	1	2	3	0	1	2
4. Washing/bathing his/her self (eg. shower or tub)	0	1	2	3	4	5	6	0	1	2	3	0	1	2
5. Getting dressed	0	1	2	3	4	5	6	0	1	2	3	0	1	2
6. Carrying an object while walking (eg. toy, book, cell or mobile phone)	0	1	2	3	4	5	6	0	1	2	3	0	1	2
7. Opening a door	0	1	2	3	4	5	6	0	1	2	3	0	1	2
8. Picking up an object off the floor	0	1	2	3	4	5	6	0	1	2	3	0	1	2
9. Getting in and out of a vehicle (eg. car, van or bus)	0	1	2	3	4	5	6	0	1	2	3	0	1	2
A1. Other activity: _____	0	1	2	3	4	5	6	0	1	2	3	0	1	2

B) Gait Function & Mobility

Consider how your child **usually** performs each of the following activities.

1) Rate how **easy or difficult** it was for your child to perform each of these activities in the **past 4 weeks**; **AND**
2) Choose what **walking aid** your child required to help them perform these activities; **AND**
3) Select **how important a goal** it is for you to have your child **improve** in each of the following activities.

During the past 4 weeks:	*Extremely Difficult / Impossible*	*Very Difficult*	*Difficult*	*Slightly Difficult*	*Easy*	*Very Easy*	*No problem at all*	WALKING AID REQUIRED: WHEELCHAIR	WALKER	TWO CANES / CRUTCHES	ONE CANE / CRUTCH / HAND SUPPORT, RAILING OR WALL	INDEPENDENT	IS THIS YOUR GOAL TO IMPROVE?: NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
10. Walking for more than 250 meters (about 2 blocks or 2 football fields)	0	1	2	3	4	5	6	0	1	2	3	4	0	1	2
11. Getting around at school (indoors)	0	1	2	3	4	5	6	0	1	2	3	4	0	1	2
12. Getting around at home	0	1	2	3	4	5	6	0	1	2	3	4	0	1	2
13. Walking for more than 15 minutes	0	1	2	3	4	5	6	0	1	2	3	4	0	1	2
14. Walking faster than usual (eg. to keep up with others)	0	1	2	3	4	5	6	0	1	2	3	4	0	1	2
15. Stepping around or avoiding obstacles	0	1	2	3	4	5	6	0	1	2	3	4	0	1	2
16. Going up and down stairs	0	1	2	3	4	5	6	0	1	2	3	4	0	1	2
17. Going up and down slopes	0	1	2	3	4	5	6	0	1	2	3	4	0	1	2
18. Walking on uneven ground (rough, rocky, sandy)	0	1	2	3	4	5	6	0	1	2	3	4	0	1	2
19. Walking on slippery surfaces (wet or icy)	0	1	2	3	4	5	6	0	1	2	3	4	0	1	2

C) Pain, Discomfort & Fatigue

Consider each of the following items.

1) Rate how **often** your child experienced pain or discomfort or tiredness in the **past 4 weeks**; **AND**
2) Choose how **severe** the pain or discomfort was; **AND**
3) Select **how important a goal** it is for you to **reduce** your child's pain or discomfort or tiredness in each of the following.

During the past 4 weeks:	*Every Day*	*Very Often (nearly every day)*	*Fairly Often (2 to 3 times a week)*	*A Few Times (once a week)*	*Once or Twice*	*None of the Time*	INTENSITY: SEVERE	INTENSITY: MODERATE	INTENSITY: MILD	INTENSITY: NONE	IS THIS YOUR GOAL TO IMPROVE?: NOT A GOAL	IS THIS YOUR GOAL TO IMPROVE?: SOMEWHAT IMPORTANT	IS THIS YOUR GOAL TO IMPROVE?: VERY IMPORTANT
20. Pain or discomfort in the feet or ankles	0	1	2	3	4	5	0	1	2	3	0	1	2
21. Pain or discomfort in the lower legs (eg. calf or shin)	0	1	2	3	4	5	0	1	2	3	0	1	2
22. Pain or discomfort in the knees	0	1	2	3	4	5	0	1	2	3	0	1	2
23. Pain or discomfort in the thighs or hips	0	1	2	3	4	5	0	1	2	3	0	1	2
24. Pain or discomfort in the back	0	1	2	3	4	5	0	1	2	3	0	1	2
25. Feeling tired while walking	0	1	2	3	4	5	0	1	2	3	0	1	2
26. Feeling tired during any other physical activities that he/she usually enjoys (eg. swimming, running, horseback riding or other sport)	0	1	2	3	4	5	0	1	2	3	0	1	2
C1. Other pain: _____	0	1	2	3	4	5	0	1	2	3	0	1	2

D) Physical Activities, Sports & Recreation

Consider how your child **usually** performs each of the following activities.

1) Rate how **easy or difficult** it was for your child to typically perform each of these activities in the **past year**; **AND**

2) Select **how important a goal** it is for you to have your child **improve** in each of the following activities.

During the past year:	***Extremely Difficult / Impossible***	***Very Difficult***	***Difficult***	***Slightly Difficult***	***Easy***	***Very Easy***	***No problem at all***	**My child did not have the chance to do this activity in the past year**	**IS THIS YOUR GOAL TO IMPROVE? NOT A GOAL**	**SOMEWHAT IMPORTANT**	**VERY IMPORTANT**
27. Running	0	1	2	3	4	5	6	☐	0	1	2
28. Participating in gliding sports (eg. skating, rollerblading, skiing, skate/snowboarding)	0	1	2	3	4	5	6	☐	0	1	2
29. Riding a bike or tricycle (with or without training wheels)	0	1	2	3	4	5	6	☐	0	1	2
30. Swimming	0	1	2	3	4	5	6	☐	0	1	2
31. Participating in sports that require running (eg. soccer, baseball, football, track)	0	1	2	3	4	5	6	☐	0	1	2
32. Participating in sports that require jumping (eg. basketball, volleyball)	0	1	2	3	4	5	6	☐	0	1	2
33. Participating in activities that require balance (eg. dance, gymnastics, martial arts)	0	1	2	3	4	5	6	☐	0	1	2
34. Climbing (eg. ladder or playground equipment)	0	1	2	3	4	5	6	☐	0	1	2
D1. Other recreational or sporting activity: _____	0	1	2	3	4	5	6		0	1	2

E) Gait Pattern & Appearance

Consider how your child **usually** walks.

1) Rate how **much of a problem** your child experienced with each of the following in the **past 4 weeks**; **AND**
2) Select **how important a goal** it is for you to have your child **improve** in each of the following.

During the past 4 weeks:	*Extremely Difficult / Impossible*	*Very Difficult*	*Difficult*	*Slightly Difficult*	*Easy*	*Very Easy*	*No problem at all*	IS THIS YOUR GOAL TO IMPROVE? NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
35. Walking with his/her feet flat on the ground	0	1	2	3	4	5	6	0	1	2
36. Walking taller or more upright (less crouched or bent at the knees)	0	1	2	3	4	5	6	0	1	2
37. Walking with his/her feet pointing straight ahead	0	1	2	3	4	5	6	0	1	2
38. Walking without dragging his/her feet	0	1	2	3	4	5	6	0	1	2
39. Walking without tripping and falling	0	1	2	3	4	5	6	0	1	2
40. Wearing footwear of his/her choice (eg. shoes, boots, sandals)	0	1	2	3	4	5	6	0	1	2
E1. Other aspect of your child's walking: _____	0	1	2	3	4	5	6	0	1	2

F) Use of Braces & Mobility Aids

Consider each of the following items.
1) Rate how **your child feels** about using each of the following in the **past 4 weeks**; **AND**
2) Select **how important a goal** it is for you to have your child to **reduce or eliminate their use of these devices.**

During the past 4 weeks:	*Very Unhappy*	*Unhappy*	*Neither Happy nor Unhappy*	*Happy*	*Very Happy*	IS THIS YOUR GOAL TO REDUCE USE / ELIMINATE? NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
41. Wearing braces or orthotics (eg. AFO)	0	1	2	3	4	0	1	2
42. Using a walking aid (eg. walker, stick, cane, crutches)	0	1	2	3	4	0	1	2
43. Using a wheelchair	0	1	2	3	4	0	1	2

- ☐ My child has not been prescribed to use braces, lifts or orthotics.
- ☐ My child chooses not to use his/her prescribed braces, lifts or orthotics.
- ☐ My child does not use any walking aids.
- ☐ My child does not use a wheelchair.

G) Body Image & Self-Esteem

Consider each of the following items.
1) Rate how **your child feels** about each of the following in the **past 4 weeks**; **AND**
2) Select **how important a goal** it is for you to have your child **improve** in each of the following.

During the past 4 weeks:	*Very Unhappy*	*Unhappy*	*Neither Happy nor Unhappy*	*Happy*	*Very Happy*	IS THIS YOUR GOAL TO IMPROVE? NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
44. The shape and position of his/her legs	0	1	2	3	4	0	1	2
45. The shape and position of his/her feet	0	1	2	3	4	0	1	2
46. The symmetry of his/her legs (in length and size)	0	1	2	3	4	0	1	2
47. The way he/she gets around compared with others	0	1	2	3	4	0	1	2
48. The way others feel about how he/she gets around	0	1	2	3	4	0	1	2
49. How he/she is treated by others	0	1	2	3	4	0	1	2

Other Goals	IS THIS YOUR GOAL TO IMPROVE?		
If there are any other goals (long or short term) that we have missed, please list them below **AND** Select **how important a goal** it is for you to have your child **improve** in each.	NOT A GOAL	SOMEWHAT IMPORTANT	VERY IMPORTANT
Other Goals:			
1.	0	1	2
2.	0	1	2
3.	0	1	2
4.	0	1	2
5.	0	1	2

Comments & Suggestions

THANK YOU FOR YOUR PARTICIPATION!