

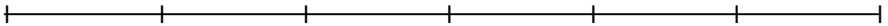
Additional file 4

GOAL-LD Child version

GOAL-LD
Gait Outcomes Assessment List
(for Lower-Limb Differences)
Child Version

1. We are trying to learn more about you and any goals you may have for treatment of your leg condition
2. Please read the instructions on each page carefully
3. Please answer all questions by circling the number and checking the box that fits best
4. 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				IMPORTANCE of GOAL					
Consider how you usually perform each of the following activities. 1) Rate how easy or difficult it was for you to perform each of these activities over the past 4 weeks; AND 2) Choose how much assistance you required to help you perform these activities; AND 3) Select how important a goal it is for you to improve in each of the following activities.																
	<i>Impossible</i> <i>No problem at all</i> 						TOTAL	MODERATE	MINIMAL OR SUPERVISED	INDEPENDENT	Not a goal	Not very important	Fairly important	Very important	Extremely important	
3. Balancing objects while walking (e.g., a cup of hot chocolate, a tray of food)	0	1	2	3	4	5	6	0	1	2	3			X		

In the above example, usual performance for 'balancing objects while walking' is rated **4 out of 6**; requires **no assistance**; and improving this is a **fairly important** goal.

Your Name: _____


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

A) Gait Function & Mobility								WALKING AID REQUIRED					IMPORTANCE of GOAL				
Consider how you usually perform each of the following activities. 1) Rate how easy or difficult it was for you to perform each of these activities in the past 4 weeks ; AND 2) Choose how much assistance you required to help you perform these activities; AND 3) Select how important a goal it is for you to improve in each of the following activities.								WHEELCHAIR	WALKER	TWO CANES OR CRUTCHES	ONE CANE / CRUTCH/HAND SUPPORT/ RAILING OR WALL	INDEPENDENT	Not a goal	Not very important	Fairly important	Very important	Extremely important
During the past 4 weeks:	<div style="display: flex; justify-content: space-between; align-items: center;"> <i>Impossible</i> <i>No problem at all</i> </div>																
1. Carrying heavy objects (e.g., grocery bags, several school books) while walking	0	1	2	3	4	5	6	0	1	2	3	4					
2. Balancing objects (e.g., a cup of hot chocolate, a tray of food) while walking	0	1	2	3	4	5	6	0	1	2	3	4					
3. Walking for more than 250 meters/820 feet (around 2 blocks or 2 football fields)	0	1	2	3	4	5	6	0	1	2	3	4					
4. Getting around in crowded spaces (e.g., school, a concert or the shopping mall)	0	1	2	3	4	5	6	0	1	2	3	4					
5. Standing for a long time (e.g., lineups, queues)	0	1	2	3	4	5	6	0	1	2	3	4					

A) Gait Function & Mobility- continued								WALKING AID REQUIRED					IMPORTANCE of GOAL				
Consider how you usually perform each of the following activities. 1) Rate how easy or difficult it was for you to perform each of these activities in the past 4 weeks ; AND 2) Choose how much assistance you required to help you perform these activities; AND 3) Select how important a goal it is for you to improve in each of the following activities								WHEELCHAIR	WALKER	TWO CANES OR CRUTCHES	ONE CANE /CRUTCH/HAND SUPPORT/ RAILING OR WALL	INDEPENDENT	Not a goal	Not very important	Fairly important	Very important	Extremely important
During the past 4 weeks:																	
6. Keeping up with friends while walking outdoors	0	1	2	3	4	5	6	0	1	2	3	4					
7. Stepping around or avoiding obstacles	0	1	2	3	4	5	6	0	1	2	3	4					
8. Going up and down stairs	0	1	2	3	4	5	6	0	1	2	3	4					
9. Going up and down ramps	0	1	2	3	4	5	6	0	1	2	3	4					
10. Walking on uneven ground (rough, rocky, sandy)	0	1	2	3	4	5	6	0	1	2	3	4					
11. Walking on wet, slippery or icy surfaces	0	1	2	3	4	5	6	0	1	2	3	4					

B) Pain / Discomfort / Fatigue							INTENSITY				IMPORTANCE of GOAL				
Consider each of the following items. 1) Rate how often you 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 pain or discomfort or tiredness in each of the following							SEVERE	MODERATE	MILD	NONE	Not a goal	Not very important	Fairly important	Very important	Extremely important
During the past 4 weeks:	<i>Every Day</i>	<i>Nearly Every Day</i>	<i>2 to 3 Times a week</i>	<i>Once a Week</i>	<i>Occasionally</i>	<i>None of the Time</i>									
12. Pain or discomfort in the feet or ankles	0	1	2	3	4	5	0	1	2	3					
13. Pain or discomfort in the lower legs (shin, calf)	0	1	2	3	4	5	0	1	2	3					
14. Pain or discomfort in the knees	0	1	2	3	4	5	0	1	2	3					
15. Pain or discomfort in the thighs or hips	0	1	2	3	4	5	0	1	2	3					
16. Pain or discomfort in the back	0	1	2	3	4	5	0	1	2	3					
17. Feeling easily tired during physical activities that I enjoy (e.g., swimming, running, or other sports)	0	1	2	3	4	5	0	1	2	3					
Other pain: _____	0	1	2	3	4	5	0	1	2	3					

C) Physical Activities, Games & Recreation									IMPORTANCE of GOAL				
Consider how you usually perform each of the following activities. 1) Rate how easy or difficult it was for you to perform each of these activities in the past year ; AND 2) Select how important a goal it is for you to improve in each of the following activities													
During the past year:	<i>Impossible</i>						<i>No problem at all</i>	I have never tried this activity	Not a goal	Not very important	Fairly important	Very important	Extremely important
	0	1	2	3	4	5	6						
18. Running fast	0	1	2	3	4	5	6	<input type="checkbox"/>					
19. Participating in gliding sports (e.g., skating, rollerblading, skiing, skate/snowboarding)	0	1	2	3	4	5	6	<input type="checkbox"/>					
20. Riding a bicycle	0	1	2	3	4	5	6	<input type="checkbox"/>					
21. Swimming	0	1	2	3	4	5	6	<input type="checkbox"/>					
22. Participating in sports that require running (e.g., soccer, baseball, football, track)	0	1	2	3	4	5	6	<input type="checkbox"/>					
23. Participating in sports that require jumping (e.g., basketball, volleyball, trampoline)	0	1	2	3	4	5	6	<input type="checkbox"/>					
24. Participating in sports that require balance (gymnastics, dance or martial arts)	0	1	2	3	4	5	6	<input type="checkbox"/>					
25. Climbing (ladder, playground equipment, wall climbing)	0	1	2	3	4	5	6	<input type="checkbox"/>					
Other recreational or sporting activity: _____	0	1	2	3	4	5	6	<input type="checkbox"/>					

D) Gait Appearance								IMPORTANCE of GOAL				
Consider each of the following items. 1) Rate how much of a problem you experienced with each of the following in the past 4 weeks ; AND 2) Select how important a goal it is for you to improve in each								Not a goal	Not very important	Fairly important	Very important	Extremely important
During the past 4 weeks:	<i>Impossible</i> 						Not a goal					
26. Walking with my feet flat on the ground	0	1	2	3	4	5	6					
27. Walking taller or more upright (less crouched or bent at the knees)	0	1	2	3	4	5	6					
28. Walking with my feet pointing straight ahead	0	1	2	3	4	5	6					
29. Walking without a limp	0	1	2	3	4	5	6					
30. Walking without tripping and falling	0	1	2	3	4	5	6					
Other aspect of my walking: _____	0	1	2	3	4	5	6					

E) Use of Braces and Assistive Devices						IMPORTANCE of GOAL						
Consider each of the following items. 1) Rate how you felt about using each of the following in the past 4 weeks ; AND 2) Select how important a goal it is for you to reduce or eliminate use of these devices						Not a goal	Not very important	Fairly important	Very important	Extremely important		
During the past 4 weeks:	<i>Very Unhappy</i> ----- <i>Very Happy</i>											
31. A shoe lift	0	1	2	3	4						<input type="checkbox"/>	I have not been prescribed a shoe lift
											<input type="checkbox"/>	I choose not to wear my shoe lift
32. A brace (e.g., AFO)	0	1	2	3	4						<input type="checkbox"/>	I have not been prescribed any type of brace
											<input type="checkbox"/>	I choose not to wear my brace
33. A prosthesis (artificial leg)											<input type="checkbox"/>	I have not been prescribed a prosthesis
											<input type="checkbox"/>	I choose not to wear my prosthesis
34. A walking aide (e.g., walker, stick, cane, crutches)	0	1	2	3	4						<input type="checkbox"/>	I do not use any walking aides
35. A wheelchair	0	1	2	3	4						<input type="checkbox"/>	I do not use a wheelchair
36. Other assistive devices (e.g., built-up bicycle pedal or _____)	0	1	2	3	4						<input type="checkbox"/>	I do not use any other assistive devices

F) Body Image & Self-Esteem						IMPORTANCE of GOAL				
Consider each of the following items. 1) Rate how you felt about each of the following in the past 4 weeks ; AND 2) Select how important a goal it is for you to improve in each of the following						Not a goal	Not very important	Fairly important	Very important	Extremely important
During the past 4 weeks:										
37. The shape and position of my legs	0	1	2	3	4					
38. The shape and position of my feet	0	1	2	3	4					
39. The symmetry of my legs (in length and size)	0	1	2	3	4					
40. Wearing my choice of footwear (e.g., shoes, boots, sandals)	0	1	2	3	4					
41. Wearing my choice of clothing (e.g., shorts, skirts, bathing suits)	0	1	2	3	4					
42. The appearance of how I get around compared with others	0	1	2	3	4					
43. The way others feel about how I get around	0	1	2	3	4					
44. How I am treated by others	0	1	2	3	4					

Other Goals	IMPORTANCE of GOAL				
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 improve in each.					
Other Goals:	Not a goal	Not very important	Fairly important	Very important	Extremely important
1.					
2.					
3.					
4.					
5.					
Comments & Suggestions					

Thank You