CENTRE FOR MOVEMENT DISORDERS

APPLICATION FORM: PARKINSON'S

For office Use: Branch

This form can be completed by the applicant, relative, friend or professional.

The application form will give the conductors an overview of your condition and how it impacts on you. Please answer as many questions as you feel able, as this will help to ensure that the initial consultation is meaningful. If you have any concerns about some questions or feel that you are not able to answer them please leave them blank.

PERSONAL INFORMATION

Name: _____

Title: Miss/Mrs/Ms/Mr Date of birth: _____

Address:_____

_____

_____

_____ Postcode: _____

Contact Telephone Numbers:

Day: _____Evening:_____

E-mail: _____

Present/previous occupation: _____

If retired please give date of retirement: _____

DATE OF DIAGNOSIS: _____

MEDICAL INFORMATION

Which side of your body has been more affected? *Please circle*

LEFT **RIGHT** **BOTH**

Do you have tremor? YES NO

Do you have stiffness? YES NO

Do you feel your movements have slowed? YES NO

Relevant medication- dosages and timings:

_____

_____

_____

_____

Additional medical/ surgical information e.g. high blood pressure, arthritis, joint replacements, accidents.

_____

_____

_____

_____

Do you experience pain? YES / NO

If you experience pain where do you feel it?

_____

_____

How much does this pain restrict your daily activity?

_____

_____

IMPACT OF YOUR CONDITION

We appreciate that each day may be different and that your abilities may vary during the day, but to help us understand how your condition affects your life please answer the following questions as best you can. If you experience a wide range of ability throughout a day please try and indicate with an average score.

The questionnaire attached is an approved questionnaire for people with Parkinson's (PDQ-39). We have chosen this as an appropriate tool to help us prepare for your consultation.

General questions:

1. Do you experience freezing / find you suddenly stop and cannot move?

YES NO

2. Are you prone to falling? YES NO

If yes, on average how frequently do you fall? _____

3. Across your drug cycle is there any significant variation in your condition?

YES NO

4. What elements/ symptoms of the condition do you feel are the most disabling for you?

_____

_____

_____

The following questions relate to how you feel your condition has affected you and your quality of life. Please circle the appropriate box:

1. How often during the past month have you…	**Never**	**Occasionally**	**Sometimes**	**Often**	**Always or cannot do**
Had difficulty doing leisure activities you would like to do?	0	1	2	3	4
Had difficult looking after your home e.g. DIY, housework?	0	1	2	3	4
Had difficulty carrying bags of shopping?	0	1	2	3	4
Had problems walking half a mile	0	1	2	3	4
Had problems walking 100yds	0	1	2	3	4
Had problems getting around the house as easily as you would like?	0	1	2	3	4
Had difficulty getting around in public?	0	1	2	3	4
Needed someone else to accompany you when you went out?	0	1	2	3	4
Felt frightened or worried about falling in public?	0	1	2	3	4
Been confined to the house more than you would like?	0	1	2	3	4

2. How often during the past month have you…	**Never**	**Occasionally**	**Sometimes**	**Often**	**Always or cannot do**
Had difficulty washing yourself?	0	1	2	3	4
Had difficulty dressing yourself?	0	1	2	3	4
Had problems doing up buttons or shoe laces?	0	1	2	3	4
Had problems writing clearly?	0	1	2	3	4
Had difficult cutting up food?	0	1	2	3	4
Had difficulty holding a drink without spilling it?	0	1	2	3	4

3. How often during the past month have you…	**Never**	**Occasionally**	**Sometimes**	**Often**	**Always**
Felt depressed?	0	1	2	3	4
Felt isolated and lonely?	0	1	2	3	4
Felt weepy or tearful?	0	1	2	3	4
Felt angry or bitter?	0	1	2	3	4
Felt anxious?	0	1	2	3	4
Felt worried about the future?	0	1	2	3	4

4. How often during the past month have you…	**Never**	**Occasionally**	**Sometimes**	**Often**	**Always**
Felt you had to conceal your Parkinson's from people?	0	1	2	3	4
Avoided situations which involve eating or drinking in public?	0	1	2	3	4
Felt embarrassed in public places due to having Parkinson's?	0	1	2	3	4
Felt worried by other people's reaction to you?	0	1	2	3	4

5. How often during the past month have you…	**Never**	**Occasionally**	**Sometimes**	**Often**	**Always**
Had problems with close personal relationships	0	1	2	3	4
Lacked support in the ways you need from your spouse or partner (please tick here if you do not have a spouse or partner)	0	1	2	3	4
Lacked support in the way you need from family and close friends?	0	1	2	3	4

6. How often during the past month have you…	**Never**	**Occasionally**	**Sometimes**	**Often**	**Always**
Unexpectedly fallen asleep during the day?	0	1	2	3	4
Had problems concentrating e.g. when watching TV or reading?	0	1	2	3	4
Felt your memory was bad?	0	1	2	3	4
Had distressing dreams or hallucinations?	0	1	2	3	4

7. How often during the past month have you…	**Never**	**Occasionally**	**Sometimes**	**Often**	**Always**
Had difficulty with your speech?	0	1	2	3	4
Felt unable to communicate properly?	0	1	2	3	4
Felt ignored by people?	0	1	2	3	4

8. How often during the past month have you…	**Never**	**Occasionally**	**Sometimes**	**Often**	**Always**
Had painful muscle cramps or spasms?	0	1	2	3	4
Had aches and pains in your joints or body?	0	1	2	3	4
Felt unpleasantly hot or cold?	0	1	2	3	4

On a scale of 0 to 100, with 100 representing full quality of life and 0 representing no quality of life, where do you feel you are at the moment?

Please put a mark on the line to indicate how you feel.

0 10 20 30 40 50 60 70 80 90 100

_____

Could you please state where you heard about Conductive Education?

_____

If you have attended Conductive Education in the past could you please give the dates and place?

_____

Do you belong to a local branch of Parkinson's UK or similar

organisation? YES/NO

If Yes, please state which _____

<u>Please complete</u> the last/following page giving us details of your GP and consultant and then sign and return this form to the address below.

Thank you for the time you have taken to provide all this information for us and we look forward to meeting you in the near future. Please ensure that you keep us up-to-date with any changes in your medical condition.

SIGNATURE: _____

DATE: _____

Please return this completed form to:

Mrs N Sandford **Direct telephone line: 0121 442 5564**
The National Institute of Conductive Education
Cannon Hill House, Russell Road, Moseley, Birmingham. B13 8RD

Can we politely request that when returning the application for to us you use a STAMP with LARGE written on it.

In exceptional circumstances we may wish to contact your GP or consultant. We will NOT contact them without discussing this with you first.

Name and address of GP:

_____

_____

GP Telephone Number:_____

Name and Hospital of Consultant:

_____

How frequently do you see your consultant? _____

Name of specialist nurse (if appropriate) _____

ANY OTHER RELEVANT MEDICAL INFORMATION YOU FEEL IT IS IMPORTANT FOR US TO KNOW:

_____

_____

_____

I agree that I have disclosed all relevant medical information to the conductors at the National Institute of Conductive Education, Birmingham. I understand that it is my duty to inform them immediately of any relevant changes in my condition or medication and agree to do so.
I agree that conductors may contact my GP or specialist should any further information be required. They will inform me of this and provide me with a copy if requested.

Signature: Date: