

Application Form: Parkinsons

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.

* Required

1. Email address *

Personal Information

2. Name *

3. Title

Mark only one oval.

Miss

Mrs

Ms

Mr

Dr

4. Date of birth

Example: January 7, 2019

5. Address *

6. Postcode *

7. Day contact telephone number *

8. Evening contact telephone number

9. Present/previous occupation

10. If retired please give year of retirement

11. Year of diagnosis

Medical Information

12. Which side of your body has been more affected?

Mark only one oval.

Left

Right

Both

13. Do you have tremor?

Mark only one oval.

Yes

No

14. Do you have stiffness?

Mark only one oval.

Yes

No

15. Do you feel your movements have slowed?

Mark only one oval.

Yes

No

16. Relevant medication - dosages and timings

17. Additional medical/surgical information

e.g. high blood pressure, arthritis, joint replacements, accidents

18. Do you experience pain?

Mark only one oval.

Yes

No

19. If you experience pain where do you feel it?

20. How much does this pain restrict your daily activity?

Mark only one oval.

	1	2	3	4	5	
Minimal	<input type="radio"/>	A great deal				

**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

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

Mark only one oval.

- Yes
 No

22. Are you prone to falling? *

Mark only one oval.

- Yes
 No

23. If yes, on average how frequently do you fall?

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

Mark only one oval.

Yes

No

25. 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. How often during the past month have you:

26. How often during the past month have you *

Mark only one oval per row.

	Never	Occasionally	Sometimes	Often	Always or cannot do
Difficulty doing leisure activities you would like to do	<input type="radio"/>				
Difficulty looking after your home e.g. DIY, housework	<input type="radio"/>				
Difficulty carrying bags of shopping	<input type="radio"/>				
Problems walking half a mile	<input type="radio"/>				
Problems walking 100yds	<input type="radio"/>				
Problems getting around the house as easily as you would like	<input type="radio"/>				
Difficulty getting around in public	<input type="radio"/>				
Needed someone else to accompany you when you went out	<input type="radio"/>				
Felt frightened or worried about falling in public	<input type="radio"/>				
Been confined to the house more than you would like	<input type="radio"/>				

27. How often during the past month have you *

Mark only one oval per row.

	Never	Occasionally	Sometimes	Often	Always
Difficulty washing yourself	<input type="radio"/>				
Difficulty dressing yourself	<input type="radio"/>				
Problems doing up buttons or shoe laces	<input type="radio"/>				
Problems writing clearly	<input type="radio"/>				
Difficulty cutting up food	<input type="radio"/>				
Difficulty holding a drink without spilling it	<input type="radio"/>				

28. How often during the past month have you *

Mark only one oval per row.

	Never	Occasionally	Sometimes	Often	Always
Felt depressed	<input type="radio"/>				
Felt isolated and lonely	<input type="radio"/>				
Felt weepy or tearful	<input type="radio"/>				
Felt angry or bitter	<input type="radio"/>				
Felt anxious	<input type="radio"/>				
Felt worried about the future	<input type="radio"/>				

29. How often during the past month have you *

Mark only one oval per row.

	Never	Occasionally	Sometimes	Often	Always
Felt you had to conceal your Parkinson's from people	<input type="radio"/>				
Avoided situations which involve eating or drinking in public	<input type="radio"/>				
Felt embarrassed in public places due to having Parkinson's	<input type="radio"/>				
Felt worried by other people's reaction to you	<input type="radio"/>				

30. How often during the past month have you *

Mark only one oval per row.

	Never	Occasionally	Sometimes	Often	Always
Had problems with close personal relationships	<input type="radio"/>				
Lacked support in the ways you need from your spouse or partner	<input type="radio"/>				
Lacked support in the way you need from family and close friends	<input type="radio"/>				

31. How often during the past month have you *

Mark only one oval per row.

	Never	Occasionally	Sometimes	Often	Always
Unexpectedly fallen asleep during the day	<input type="radio"/>				
Had problems concentrating e.g. when watching TV or reading	<input type="radio"/>				
Felt your memory was bad	<input type="radio"/>				
Had distressing dreams or hallucinations	<input type="radio"/>				

32. How often during the past month have you *

Mark only one oval per row.

	Never	Occasionally	Sometimes	Often	Always
Had difficulty with your speech	<input type="radio"/>				
Felt unable to communicate properly	<input type="radio"/>				
Felt ignored by people	<input type="radio"/>				

33. How often during the past month have you *

Mark only one oval per row.

	Never	Occasionally	Sometimes	Often	Always
Had painful muscle cramps or spasms	<input type="radio"/>				
Had aches and pains in your joints or body	<input type="radio"/>				
Felt unpleasantly hot or cold	<input type="radio"/>				

34. Where do you feel you are at the moment? *

Mark only one oval.

	0	1	2	3	4	5	6	7	8	9	10	
No quality of life	<input type="radio"/>	Full quality of life										

35. Could you please state where you heard about Conductive Education *

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

37. Do you belong to a local branch of Parkinson's UK or similar organisation? *

Mark only one oval.

Yes

No

38. If yes, please state which

Additional Details

39. Do you have access to a computer, iPad or tablet?

Mark only one oval.

Yes

No

40. Would you be interested in remote sessions if necessary?

Mark only one oval.

Yes

No

GP
Details

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

41. Name of GP

42. Address of GP

43. GP Telephone Number

44. Name and Hospital of Consultant

45. How frequently do you see your consultant?

46. Name of specialist nurse (if appropriate)

47. Any other relevant medical information you feel it is important for us to know?

48. 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. *

Check all that apply.

I agree

49. Signature / Type name

50. Date

(if printed)

Example: January 7, 2019

If printed, 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.

Please return this completed form to:

Mrs N Sandford
Direct telephone line: 0121 442 5564

NICE – Centre for Movement Disorders
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.

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