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 *

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	◯	◯	◯	◯	◯	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					
Difficulty looking after your home e.g. DIY, housework					
Difficulty carrying bags of shopping					
Problems walking half a mile					
Problems walking 100yds					
Problems getting around the house as easily as you would like					
Difficulty getting around in public					
Needed someone else to accompany you when you went out					
Felt frightened or worried about falling in public					
Been confined to the house more than you would like					

27. How often during the past month have you *

Mark only one oval per row.

	Never	Occasionally	Sometimes	Often	Always
Difficulty washing yourself					
Difficulty dressing yourself					
Problems doing up buttons or shoe laces					
Problems writing clearly					
Difficulty cutting up food					
Difficulty holding a drink without spilling it					

28. How often during the past month have you *

Mark only one oval per row.

	Never	Occasionally	Sometimes	Often	Always
Felt depressed					
Felt isolated and lonely					
Felt weepy or tearful					
Felt angry or bitter					
Felt anxious					
Felt worried about the future					

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					
Avoided situations which involve eating or drinking in public					
Felt embarrassed in public places due to having Parkinson's					
Felt worried by other people's reaction to you					

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					
Lacked support in the ways you need from your spouse or partner					
Lacked support in the way you need from family and close friends					

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					
Had problems concentrating e.g. when watching TV or reading					
Felt your memory was bad					
Had distressing dreams or hallucinations					

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					
Felt unable to communicate properly					
Felt ignored by people					

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					
Had aches and pains in your joints or body					
Felt unpleasantly hot or cold					

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	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	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:

The Adult Department
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.