

How Spasticity Is Affecting You

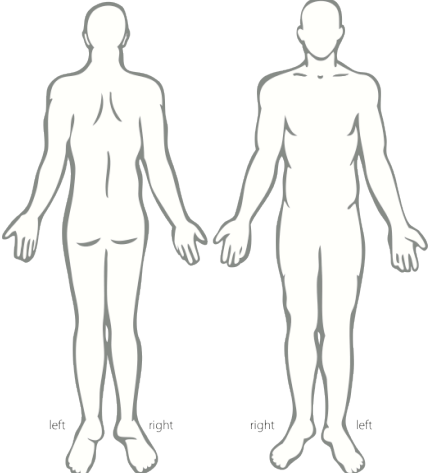
Date:		Telephone:	
Name:		Caregiver's Name:	
Address:		City, State, Zip Code:	
Doctor's Name:		Doctor's Telephone:	

Do you have any of the following symptoms? **Please indicate which activities below are impacted by your symptoms.**

Tight Limbs Charley Horse/Cramps Spasms (involuntary movement)	Feeding Toileting Dressing	Bathing Sleeping Walking	
Do you use an assistive device:	Yes No	Have you fallen in the last 3 months?	Yes No

Please list the medications that you are currently taking: _____

If you experience pain associated with spasticity or tight, stiff muscles, please use the picture below to indicate where.

	<p>Pain Numeric Rating System Rate your pain over the last _____ (day, week, month)</p> <p style="text-align: center;">No Pain Worst Pain</p> <p style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</p>
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If you experience spasms, please indicate where and the severity of the spasm:

Spasm Rating Scale

- 0 = No spasm
- 1 = Mild spasms induced by stimulation
- 2 = Infrequent full spasms occurring less than once

- 0 = No spasm
- 1 = Mild spasms induced by stimulation
- 2 = Infrequent full spasms occurring less than once per hour
- 3 = Spasms occurring more than once per hour
- 4 = Spasms occurring more than 10 times per hour

Head	Arms
Neck	Hands
Face	Legs
Trunk	Feet

Patient Name:		Date:	
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Notes/Comments: _____

Only complete this section if this is NOT your first visit to the clinic for managing your spasticity.

Since your last visit, your spasticity is:
 Improved The Same Worse

Patient's Global Impression of Change (PGIC) Scale*

Since beginning treatment at this clinic, how would you describe the change (if any) in ACTIVITY LIMITATIONS, SYMPTOMS, EMOTIONS, and OVERALL QUALITY OF LIFE related to your condition? (select one)

- No change (or condition has gotten worse) 1
- Almost the same, hardly any change at all 2
- A little better, but no noticeable change 3
- Somewhat better, but the change has not made any real difference 4
- Moderately better, and a slight but noticeable change 5
- Better, and a definite improvement that has made a real and worthwhile difference 6
- A great deal better, and a considerable improvement that has made all the difference 7

In a similar way, please circle the number below that matches your degree of change since beginning care at this clinic:

Much Better	No Change	Much
Worse		

0 1 2 3 4 5 6 7 8 9

10

Patient's/Caregiver's Signature: _____ Date: _____

* Hurst H, Bolton J. Assessing the clinical significance of change scores recorded on subjective outcome measures.
Journal of Manipulative Physiological Therapeutics (IMPT) 2004;27:26-35.

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