

Please list all the drugs you take now, present levels of dosage and times you take them.

.....
.....

Please give a brief history of your drugs and levels of dosage since diagnosis.....

.....
.....

Describe any side effects of your drugs.

.....
.....
.....

Has there been any recent change in your medication?

.....
.....
.....

Do you have any other medical conditions ? If yes, please expand on your answer and tell us of any treatment or medication you receive.....

.....
.....

Heart problems including angina and blood pressure:.....

.....
.....

Diabetes:.....

.....
.....

Epilepsy:.....

.....
.....

Arthritis or joint problems:.....

.....
.....

Do you suffer from bouts of depression? Yes/ No

If yes, how frequent are they and how long do they last?.....

.....
.....

Do you have any problems with bowel or bladder continence?.....
.....
.....

Do you have any known allergies:.....
Please describe your reaction.....
.....

Other serious medical condition that we should know about:.....
.....

Present Abilities

This section is for you to tell us, in as much detail as you can, what you are able to do and what aids, equipment or help you need to allow you to do them.

General

Turning over in bed:.....
.....
.....
.....

Standing up from a chair:.....
.....
.....
.....

Walking in the house:.....
.....
.....
.....

Walking in the street:.....
.....
.....
.....

Do you ever "freeze" when walking? Yes/ No

Do you often fall over ? Yes/No

How do you get up from the floor?.....
.....
.....
.....

Self Help.

How do you manage :-

Large garments.....
.....
.....

Buttons, zips etc.....
.....
.....

Bathing/showering.....
.....
.....

Eating

Chewing.....
.....

Swallowing.....
.....
.....

Use of knife and fork.....
.....
.....

Drinking.....
.....
.....

Difficulties you may be experiencing.

Do you have a tremor? Yes/No

If yes, when did it start and in which part of your body?.....
.....
.....

Do you suffer from stiffness? Yes/No

When did it start and in which part of your body?.....
.....
.....

Do you suffer from dyskinesia? Yes/No

If yes, are the movements painful?

Do you have a balance problem? Yes/ No

If yes give details.....

Do you have any "off" periods? Yes/ No

If yes, what percentage off the waking day?

Please describe any difficulties you have with your

Writing.....

Speech:.....

Hearing:.....

Vision:.....

Memory.....

Further Information

Please give any further information you feel we should know about you.

.....
.....
.....

Are you aware of the fees for this service?.....

Have you ever participated in Conductive Education before?

If yes, please tell us where and when.....

.....
.....

Where did you first hear about Conductive Education?

.....

When you have completed this form to your satisfaction please sign and return it to the address below.

Signed.....Date.....

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CPC
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Rochester
Kent ME3 8UJ

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