Specialist Parkinson's Integrated Rehabilitation Team Trial (SPIRiTT)

Background questionnaire for Person with Parkinson's

THIS SECTION TO BE COMPLETED BY THE RESEARCHER

We would be grateful if you could provide as much information as possible
All information collected is treated with complete confidentiality

Date: _ _ / _ _ _ / _ _ _ _ **Time:** _ _ : _ _ AM PM **Location:** ☐ Home ☐ Other _____

Person completing form: ☐ Carer ☐ Person with Parkinson's ☐ Researcher ☐ Other (please specify): _____

FALLS QUESTIONNAIRE

Please place a tick √ in the box that is most appropriate to you.

1) In the LAST 3 MONTHS, have you fallen? ☐ Yes ☐ No
2) If you have fallen in the LAST 3 MONTHS, roughly how many times have you fallen? _ _ _ times
3) Did you hurt yourself on any of these occasions? ☐ Yes ☐ No
4) Were you able to get up from the floor/ground? ☐ Yes ☐ No
5) Did you see a doctor? ☐ Yes, A&E ☐ Yes, GP ☐ No
6) Are your falls related to freezing? ☐ Yes ☐ No ☐ Don't know

SPIRiTT Unique Identification Number: **Assessment time-point**

TIMED UP AND GO

The Timed Up and Go test measures in seconds the time taken by an individual to stand up from a standard arm chair, walk a distance of 3 metres, turn, walk back to the chair and sit down again at their own normal walking pace. Please complete the table below.

Chair seat height:	_ _ _cm		**Chair arm height:**	_ _ _cm
Arms used to get out of the chair:	☐ Yes ☐ No			
Use of walking aid:	☐ Yes	☐ No	If Yes, which aid:	
Time taken:	**_ _ _ _ seconds**			

Comments *(please provide details of the chair that was used e.g. dining room chair)*:

UNIFIED PARKINSON'S RATING SCALE

Please place a tick √ in the box which best describes the participant's posture and gait.

Posture	Gait
☐ Normal erect	☐ Normal
☐ Not quite erect, slightly stooped posture; could be normal for older person	☐ Walks slowly, may shuffle with short steps, but no festination (hastening steps) or propulsion
☐ Moderately stooped posture, definitely abnormal; can be slightly leaning to one side	☐ Walks with difficulty, but requires little or no assistance; may have some festination, short steps or propulsion
☐ Severely stooped posture with kyphosis; can be moderately leaning to one side	☐ Severe disturbance of gait, requiring assistance
☐ Marked flexion with extreme abnormality of posture	☐ Cannot walk at all even if assisted

YALE SINGLE ITEM SCREENING TOOL

Do you frequently feel sad or depressed? ☐ Yes ☐ No

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ABRIDGED EMERSON AND ENDERBY RATING SCALE

Please tick √ the most appropriate box that describes the participant's voice and articulation.

Voice	Articulation
☐ No impairment; voice normal for age and sex	☐ No impairment; normal
☐ Slight impairment; slight abnormal nasality, quality or volume, noticeable to trained observer	☐ Slight impairment; a few articulatory substitutions, not usually affecting intelligibility in spontaneous speech
☐ Moderate impairment; abnormal nasality, quality or volume, noticeable to casual observer	☐ Moderate impairment; abnormal articulation is noticeable to the casual observer and sometimes affects intelligibility
☐ Severe impairment; severely abnormal nasality, quality or volume	☐ Severe impairment; many sounds are articulated abnormally and intelligibility is markedly affected

FRENCHAY SUMMARY

Using the instructions and grading system provided, please complete the following table.

		Respiration		Phonation				Intelligibility		
Normal function	A									
	B									
	C									
	D									
No function										
	E									
		Rest	Speech	Time	Pitch	Volume	Speech	Words	Sentences	Conversation

UNIFIED PARKINSON'S RATING SCALE

Please place a tick √ in the box which best describes the participant's speech.

Is the speech:
☐ Normal
☐ Mildly affected; no difficulty being understood
☐ Moderately affected; sometimes asked to repeat statements
☐ Severely affected; frequently asked to repeat statements
☐ Unintelligible most of the time

SPIRiTT Unique Identification Number: **Assessment time-point**

ABOUT THE SERVICES YOU RECEIVE

Please answer the following questions by placing a tick √ in the appropriate box.

1) In the LAST 3 MONTHS, have you got any new aids/adaptations/equipment (such as bath chair)? ☐ Yes ☐ No

2) If you have got any new aids/adaptations/equipment in the LAST 3 MONTHS, please provide details below

Type of aids/adaptations/equipment	*New aids/adaptations/ equipments or types of changes*	*Who paid for this?*
Special equipment (such as walking stick, bath seats, kitchen ware)		
Changes to home (such as stairlift, shower cubicle)		
Other (please specify): _____		

3) In the LAST 3 MONTHS, because of your Parkinson's

How many TIMES have you visited the:	*What was the reason for your visit?*	*Did you use hospital transport?*		
		Yes, all of the time	*Yes, some of the time*	*No, not at all*
Accident and Emergency (A&E)? ☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10				
hospital as a day case? ☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10				
hospital overnight? ☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10 How MANY NIGHTS IN TOTAL did you stay? _ _ _				

4) In the LAST 3 MONTHS, have you attended a day care centre? ☐ Yes ☐ No

5) If you do attend a day care centre, please provide details below

How many times a week do you go?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

How long do you stay for each visit?

☐ Usually half a day
☐ Sometimes half a day
☐ Sometimes full day
☐ Usually full day

How do you usually get to there?

☐ Private transport
☐ Private taxi
☐ Public transport
☐ Local authority transport
☐ Hospital transport
☐ Other (please specify): _____

6) In the LAST 3 MONTHS, have you lived anywhere else besides your own home? ☐ Yes ☐ No

7) If you have lived elsewhere, what type of accommodation did you stay in at the time and for how long?

☐ Care home _____ nights spent in Care home

☐ Nursing home _____ nights spent in Nursing home

☐ Other (please specify): _____ _____ nights spent

8) In the LAST 3 MONTHS, please provide details of any health services used or received for your Parkinson's below

Service (please tick box if used/received)	*Total number of times*	*Were you visited at home?*		*Did you, your family/ friend pay for the service?*	
		No	*Yes*	*No*	*Yes*
☐ Hospital neurologist					
☐ Hospital geriatrician					
☐ General practitioner (GP)					
☐ Telephoned GP at surgery					
☐ Emergency GP out of hours					
☐ Parkinson's nurse specialist					
☐ District or practice nurse					
☐ Physiotherapist					
☐ Occupational therapist					
☐ Speech and language therapist					
☐ Psychiatrist					
☐ Psychologist					
☐ Alternative therapist					
☐ Social worker					
☐ Health care assistant					
☐ Parkinson's UK information and support worker					
☐ NHS Direct (telephone helpline)					
☐ Other (please specify): _____					

9) In the LAST 3 MONTHS, have you had any tests for Parkinson's (such as brain scan, blood test)? ☐ Yes ☐ No

10) If you have had any tests in the LAST 3 MONTHS, please tell us what they were:

_____

11) How many different prescribed medications do you take each day? _ _ _ medications

12) How many of these prescribed medications are for Parkinson's? _ _ _ medications

13) Do you take any medications for side effects of Parkinson's?

☐ Constipation ☐ Depression ☐ Extra salivation ☐ Overactive bladder ☐ Other (please specify): _____

14) Are you exempt from paying for your prescriptions? ☐ Yes ☐ No ☐ Don't know

15) Over the last month, about how much have you spent on over-the-counter medicines or remedies? £_____

16) Please tell us what over-the-counter medicines or remedies you have bought:

_____

17) Medication profile (to be completed by researcher). Please list below any Parkinson's drugs you currently use

Name of Parkinson's drug	*Dosage*	*Frequency*

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18) In the LAST 3 MONTHS, please provide information on any of the paid social services you have used or received below (please do not include care from the live-in carer even if paid)

Service (please tick box if used/received)	*Amount/frequency (e.g. hours in a day, number of times in a week)*	*Who has arranged the service?*				*Did you, your family/ friend pay for the service?*	
		Health/ social services	*Participant/ family*	*Voluntary*	*Other*	*Yes*	*No*
☐ Personal care (e.g. dressing, washing)							
☐ Home help (e.g. cleaning, garden)							
☐ Nursing							
☐ Transport (e.g. Dial-a-Ride)							
☐ Community/personal alarm (e.g. Careline)	How many times have you used it in total in the LAST 3 MONTHS? ☐☐☐☐☐☐☐ 1 2 3 4 5 6 7						
☐ Meals-on-Wheels	How many times do you have it A WEEK? ☐☐☐☐☐☐☐ 1 2 3 4 5 6 7						

19) In the past month, have you received unpaid help from family or friends? ☐ Yes ☐ No

20) If yes, you did receive unpaid help from family or friends, please provide details below

Type of help (please tick box if received)	*Who provides the help?*	*Amount/frequency (e.g. hours in a day, number of times in a week)*
☐ Personal care (e.g. dressing, washing)		
☐ Home help (e.g. cleaning, garden)		
☐ Transport		
☐ Other (please specify):_____		