LSVT BIG® Initial Interview

Identifying Information

Name: ____________________________ email address: ___________________________

Address: ____

City: ______________ State: ______ Zip: _____________ Phone: _________________

Fax: ____________________ Age: ______________ Date of Birth: _________________

Patient Medical Record #: ____

Referring Physician: ____

Date and Time of Day of Initial Interview: ____________________________________

Diagnosis/Stage: ____________________ Date of Initial Diagnosis: ______________

Time of Last Park med: ________________ Time of Next Park med: ______________

Neurologist: _____________________________ Phone: ________________________

Address: ____

Neurosurgeon: ___________________________ Phone: ________________________

Address: ____

Neurological and Other Medical Information

What were your initial symptoms of Parkinson disease? _________________________

____

Do you have any tremor? Yes ____ No _____ If yes, please describe: ______________

____

Do you have any other medical problems? Yes _______ No _____ If yes, please describe: ________

____

Copyright© 2014 LSVT Global, Inc. v.03_06-16-14

This page may be reproduced for clinical use by LSVT BIG Certified Clinicians

Do you have any pain? Yes ______ No _____ If yes, please describe: ________________________

____

Pain Rating (on a scale of 1-10 with 10 being most severe): ________________________________

Medication Information:

Medication for Parkinson disease: ____

____

Other Medications: ____

In what ways are your medication(s) for Parkinson's helpful? _______________________________

____

Does your Parkinson medication affect your movement? Yes _______ No _____ If yes, please describe: ____

Do you experience "on/off" symptoms? Yes ____ No _____ If yes, please describe: _____________

____

Do you experience any dyskinesias? Yes ______ No _____ If yes, please describe: _____________

____

Surgical Information:

Have you had neurosurgery? ____________________ Orthopedic surgery? ____________________

If yes, what procedure, when, where, by whom? ____

____

____

Copyright© 2014 LSVT Global, Inc. v.03_06-16-14

This page may be reproduced for clinical use by LSVT BIG Certified Clinicians

Social Information:

Do you live alone? ____

If no, whom do you live with? ____

What type of environment do you live in? House _______________ Apartment _______________

Condo_________________ Mobile Home _________________ Assisted Living _________________

Other ____

How many stairs do you have where you enter your home? ___________________________________

How many stairs within your home? ____

Are there railings with the stairs? ____

Are you employed? Yes ____ No _____ If yes, what do you do? ______________________________

____

If you are no longer employed, what type of work did you do in the past? ________________________

____

What household chores do you participate in? ____

____

Do you drive? Yes ___ No _____ If yes, what kind of vehicle and how frequently do you drive? _____

____

Do you use any type of assistive device such as a walker, cane, rollator, etc.? Yes ______ No _____

If yes, please describe? ____

____

What type of leisure activities do you enjoy? ____

____

____

Copyright© 2014 LSVT Global, Inc. v.03_06-16-14

This page may be reproduced for clinical use by LSVT BIG Certified Clinicians

What type of leisure activities did you used to participate in if you are no longer participating in them now? ____

____

____

Would you rate yourself as sedentary, moderately active, or very active? ____________________

What type of exercise do you partake in? ____________________________________

____

Motor Symptoms

When did you first start to notice changes in your movement you associate with Parkinson disease? For example, changes in speed of movement with walking, getting dressed, increased difficulties getting in/out of bed or certain chairs, balance impairments, etc. ____________________________

____

What are your current symptoms? ____

____

What is your most significant problem related to movement today? ____________________________

____

What do you do when you want to move the best you possible can? ____________________________

____

Has Parkinson disease caused you move less or be less active? Yes ____ No _____ If yes, how much less? ____

Why has Parkinson disease caused you to move less? ____________________________________

____

Copyright© 2014 LSVT Global, Inc. v.03_06-16-14

This page may be reproduced for clinical use by LSVT BIG Certified Clinicians

Have you noticed if your movement is slower than it used to be? For example, walking, getting dressed, doing household chores, bathing, etc. Yes ____ No _____ If yes, please describe: _______

____

Have you or others noticed any changes in your posture? Yes ______ No _____ If yes, please

describe: ____

Have you noticed if your balance is worse now compared to before you had Parkinson disease?

Yes ____ No _____ If yes, please describe: ______________________________________

How many (if any) falls have you had in the last year? _____________________________

The last 3 months? ____

The last month? ____

The last week? ____

What factors contributed to those falls? _______________________________________

____

If you have not had any falls in the last year, do you sometimes experience “near falls” where you are

able to “catch” yourself and self -recover? Yes ___________ No ____________

How often do you have these “near falls”? _____________________________________

Have you noticed changes in your stamina? Yes ______ No _____ If yes, please describe: _______

____

Does your body feel fatigued at the end of the day? Yes _____ No _____ If yes, please describe:

____

Have you noticed any freezing with your movement? Yes _____ No _____ If yes, when do you

notice freezing? ____

____

Copyright© 2014 LSVT Global, Inc. v.03_06-16-14

This page may be reproduced for clinical use by LSVT BIG Certified Clinicians

Are there some activities you now need help with because of your Parkinson disease? For example, getting socks or shoes on, buttoning, getting up from low chairs, walking on uneven ground, etc. ____

____

____

____

Have you noticed any changes in the functioning of your hands? Yes ______ No _____

If yes, please describe: Right hand:____

Left hand:____

Has Parkinson disease caused you to use your more affected hand less? Yes _________ No _______

If you have problems with your hand function today, what is/are the most significant problem(s)?
____

____

Have you noticed any changes in your ability to:

Button: ____

Dial the phone: ____

Open containers: ____

Manipulate money: ____

Tie shoes: ____

Write: ____

Type or use a computer: ____

Other:____

Have you noticed if your hand movements are smaller than they used to be? Yes ________ No _____

If yes, please describe:____

Copyright© 2014 LSVT Global, Inc. v.03_06-16-14

This page may be reproduced for clinical use by LSVT BIG Certified Clinicians

Have you noticed if your hand movements are slower than they used to be? Yes ___ No _____

If yes, please describe:____

Have you noticed if your hands feel any weaker than they used to? Yes ____ No _____

If yes, please describe:____

Questions to help determine/create "Magical Calibration Moments"

Movement Situations:

If you had one situation in which you wanted move well, what would it be? ____________________

____

Describe your day in terms of mobility or movement activity/situations (i.e., elicit from the patient information about whom is present when the patient moves, how the patient moves around, when the movement occurs and for what purpose).

AM ____

____

PM ____

____

When do you find it most difficult to move? ____

Why is it difficult to move in these situations/times that you mentioned? ______________________

____

What would you like to improve about your ability to move? ______________________________

____

Copyright© 2014 LSVT Global, Inc. v.03_06-16-14

This page may be reproduced for clinical use by LSVT BIG Certified Clinicians

What aspect of your Parkinson disease bothers you the most? ________________________________

____

Other comments: ____

____

Are there things you stopped doing because of Parkinson disease (e.g., work activities, volunteer activities, leisure activities, exercises, etc.) ____

____

____

____

Why have you given up these activities? Because of problems with Moving, Speaking, Motivation?

Explain: ____

____

____

____

Copyright© 2014 LSVT Global, Inc. v.03_06-16-14

This page may be reproduced for clinical use by LSVT BIG Certified Clinicians