

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:

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?

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?

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? .

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?

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: _____

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? _____

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: _____
