

Name: _____

Date: _____

Marital Status: _____

of Children: _____

Years of Education: _____

In an effort to provide you with the best and most comprehensive care we are asking you to complete the following questionnaires. The answers you provide to the questions will be used by your Neurologist to determine the best way to provide you care.

The Care Team will collect these from you when you are brought back to your room. In addition, the Care Team may ask you some other questions and enter your answers directly into our electronic medical system. All results will be a part of your medical record here at University of Florida.

If you have any questions, please do not hesitate to discuss them with your Neurologist.

Thank you,
Department of Neurology
University of Florida

The questionnaires on the next three pages
(Pages 1, 2 & 3) are to be completed by the
PERSON ACCOMPANYING THE PATIENT AT
TODAY'S VISIT

(otherwise by the patient if unaccompanied).

THE BARTHEL INDEX

Patient Name: _____

Date: _____

Activity _____ **Score** _____

FEEDING

0 = unable

5 = needs help cutting, spreading butter, etc., or requires modified diet

10 = independent

BATHING

0 = dependent

5 = independent (or in shower)

GROOMING

0 = needs to help with personal care

5 = independent face/hair/teeth/shaving (implements provided)

DRESSING

0 = dependent

5 = needs help but can do about half unaided

10 = independent (including buttons, zips, laces, etc.)

BOWELS

0 = incontinent (or needs to be given enemas)

5 = occasional accident

10 = continent

BLADDER

0 = incontinent, or catheterized and unable to manage alone

5 = occasional accident

10 = continent

TOILET USE

0 = dependent

5 = needs some help, but can do something alone

10 = independent (on and off, dressing, wiping)

TRANSFERS (BED TO CHAIR AND BACK)

0 = unable, no sitting balance

5 = major help (one or two people, physical), can sit

10 = minor help (verbal or physical)

15 = independent

MOBILITY (ON LEVEL SURFACES)

0 = immobile or < 50 yards

5 = wheelchair independent, including corners, > 50 yards

10 = walks with help of one person (verbal or physical) > 50 yards

15 = independent (but may use any aid; for example, stick) > 50 yards

STAIRS

0 = unable

5 = needs help (verbal, physical, carrying aid)

10 = independent

TOTAL (0-100): _____

Functional Activities Questionnaire

Please circle the box that best applies.

1. Writing checks, paying bills, balancing checkbook

Dependent	Requires assistance	Has difficulty but does by self	Normal	Never did (the activity) but could do now	Never did and would have difficulty now
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2. Assembling tax records, business affairs, or papers

Dependent	Requires assistance	Has difficulty but does by self	Normal	Never did (the activity) but could do now	Never did and would have difficulty now
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3. Shopping alone for clothes, household necessities, or groceries

Dependent	Requires assistance	Has difficulty but does by self	Normal	Never did (the activity) but could do now	Never did and would have difficulty now
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4. Playing a game of skill, working on a hobby

Dependent	Requires assistance	Has difficulty but does by self	Normal	Never did (the activity) but could do now	Never did and would have difficulty now
-----------	---------------------	---------------------------------	--------	---	---

5. Heating water, making a cup of coffee, turning off stove after use

Dependent	Requires assistance	Has difficulty but does by self	Normal	Never did (the activity) but could do now	Never did and would have difficulty now
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6. Preparing a balanced meal

Dependent	Requires assistance	Has difficulty but does by self	Normal	Never did (the activity) but could do now	Never did and would have difficulty now
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7. Keeping track of current events

Dependent	Requires assistance	Has difficulty but does by self	Normal	Never did (the activity) but could do now	Never did and would have difficulty now
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8. Paying attention to, understanding, discussing TV, book, magazine

Dependent	Requires assistance	Has difficulty but does by self	Normal	Never did (the activity) but could do now	Never did and would have difficulty now
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9. Remembering appointments, family occasions, holidays, medications

Dependent	Requires assistance	Has difficulty but does by self	Normal	Never did (the activity) but could do now	Never did and would have difficulty now
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10. Traveling out of neighborhood, driving, arranging to take buses

Dependent	Requires assistance	Has difficulty but does by self	Normal	Never did (the activity) but could do now	Never did and would have difficulty now
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Pfeffer, R.I., Kurosaki, T.T., Harrah, C.H. Jr., Chance, J.M., & Filos, S. (1982). Measurement of functional activities in older adults in the community. *Journal of Gerontology*, 37(3), 323-329. Reprinted with permission of Oxford University Press.

The questionnaire on the next page (Page 4) is
to be completed by the **PATIENT.**

Patient Name: _____ **Date:** _____

Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / NO
2. Have you dropped many of your activities and interests? YES / NO
3. Do you feel that your life is empty? YES / NO
4. Do you often get bored? YES / NO
5. Are you in good spirits most of the time? YES / NO
6. Are you afraid that something bad is going to happen to you? YES / NO
7. Do you feel happy most of the time? YES / NO
8. Do you often feel helpless? YES / NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES / NO
10. Do you feel you have more problems with memory than most? YES / NO
11. Do you think it is wonderful to be alive now? YES / NO
12. Do you feel pretty worthless the way you are now? YES / NO
13. Do you feel full of energy? YES / NO
14. Do you feel that your situation is hopeless? YES / NO
15. Do you think that most people are better off than you are? YES / NO

Source: <http://www.stanford.edu/~yesavage/GDS.html> This scale is in the public domain.