The Adult Cerebral Palsy Movement

SUMMARY OF ANNUAL SELF CHECK

Below are the areas you have filled out on the Questionnaire.
Tick 2-3 boxes you would like to discuss with your GP and why? This will assist you in having a focussed conversation and move forward together with your GP.

Date .....

Medical Support	☐	.....
Medical history	☐	.....
Physical activity	☐	.....
Pain	☐	.....
Fatigue	☐	.....
Mobility	☐	.....
Falls	☐	.....
Sleep	☐	.....
Mental health	☐	.....
Men's Health / Women's health	☐	.....
Relationships & Social Life	☐	.....

TIPS FOR PREPARING FOR YOUR GP APPOINTMENT

- Take a pencil and pen with you to the appointment.
- Write down the issue that you want to discuss beforehand.
- Ask the GP if you can record the conversation.
- Book a double appointment with your GP to discuss anything in detail (if possible).
- Take someone with you to help listen to all the information.
- Discuss any assistance needed for your examination beforehand.
- Ring your GP practice beforehand to book in-person, video or telephone appointment as needed.
- Ring your GP practice before the appointment to check physical accessibility to attend service (e.g. wheelchair access, disability toilets, examination tables, and ramps).

CEREBRAL PALSY ANNUAL SELF CHECK

This Annual Self Check was adapted by UP, with permission, from the Annual Self Check produced by Cerebral Palsy Scotland. It was adapted based on current evidence working in partnership with adults with cerebral palsy. We'd like to thank the members of the advisory group who contributed to this leaflet.

This checklist can be used to monitor your health every year and can be taken to your doctor for further discussion on areas where there are changes. It will take approximately 20-30 minutes to complete.

GENERAL HEALTH

1. In general, how would you say your health is?

Excellent ☐ Good ☐ Fair ☐ Poor ☐ Variable ☐

If you selected fair, poor or variable, can you give reasons why?

.....

MEDICAL SUPPORT

2. What support do you have available? (tick all that apply)

- Dentist/special needs dentist ☐
- Occupational therapist ☐
- Psychologist/mental health practitioner ☐
- Special seating/ wheelchair services ☐
- Optician ☐
- Carers/home help ☐
- Continence advisors ☐
- Community nurse/ district nurse ☐
- Speech and language therapist ☐
- Orthotics/medical appliances ☐
- Assistive technology ☐
- Pharmacist ☐
- Personal assistants ☐
- Others .....
- Physiotherapist (e.g. neuro, MSK, community, hydro) ☐
- Dietician/nutritionist ☐
- Podiatrist/chiropodist ☐
- Social worker ☐
- Audiologist ☐
- Respite ☐

3. Have you had the experience of social prescribing facilities in your area?

Yes ☐ No ☐

4. Please write the name of the medical support person, if known

.....

5. When was the last time you saw them?

6 months ago ☐ 1 year ago ☐

Other, please explain

.....

6. **Are you getting the care and support you need?**

Yes ☐ No ☐

Other, please explain

.....

MEDICAL HISTORY

It is useful to understand about other chronic conditions.

7. **Do you have a history of chronic conditions? (tick all that apply)**

FAMILY HISTORY				PERSONAL HISTORY			
Cancer	☐	Lung condition	☐	Cancer	☐	Lung condition	☐
Heart condition	☐	Obesity	☐	Heart condition	☐	Obesity	☐
Stroke	☐	Liver disease	☐	Stroke	☐	Liver disease	☐
Arthritis/ joint pain	☐	Osteoporosis	☐	Arthritis/ joint pain	☐	Osteoporosis	☐
Muscle pain	☐	Stomach problems	☐	Muscle pain	☐	Stomach problems	☐
Diabetes	☐	Kidney disease	☐	Diabetes	☐	Kidney disease	☐
Other				Other			

Note: If you haven't discussed any of these conditions with your GP in the last year, it might be worth discussing.

8. **Have you noticed significant increase or decrease in your weight in the last year?**

Yes ☐ No ☐ Unable to check ☐

If Yes or unable to check, please explain

.....

PHYSICAL ACTIVITY

Keeping physically active as someone with CP may need to be adapted but it is still just as important for our well-being and physical health.

9. **Have you become more or less physically active in the last year?**

Yes ☐ No ☐

Other, please explain

.....

10. Tick the activities/exercises you do regularly:

Walking	☐	Horse riding	☐	Gym/strength	☐	Gardening	☐
Adapted cycling	☐	Dancing	☐	Stretching	☐	Hoovering	☐
Swimming	☐	Taichi	☐	Boccia	☐	Dish washing	☐
Race running	☐	Pilates	☐	Wheelchair sports	☐	Cleaning house	☐
Seated aerobics	☐	Yoga	☐			Shopping	☐
Treadmill	☐	Mat exercises	☐	Hiking	☐	Travelling	☐
				Climbing stairs	☐		

Other, please explain .....

11. Has there been a reducton in your physical activity in the last year, or over the last 5 years?

Yes ☐ No ☐

Other, please explain

.....

SYMPTOMS

PAIN

Pain can impact negatively on your function and quality of life.

12. Do you experience physical pain?

Yes ☐ No ☐

13. Has this got worse in the last year?

Yes ☐ No ☐

If Yes, please explain

.....

14. Please select that best describes your pain level in the last year:

- ☐ Have been feeling physically uncomfortable because of stiffness but no pain.
- ☐ Occasional pain in certain parts of my body.
- ☐ Increased intensity and frequency of pain.
- ☐ High tolerance to pain

15. **How would you rate your pain? (Circle ONE number):**

Mild Pain: Nagging, annoying, but doesn't interfere with daily living activities. **Score 1-3**

Moderate Pain: Interferes significantly with daily living activities. **Score 4-6**

Severe Pain: Disabling; unable to perform daily living activities. **Score 7-10**

 1 2 3 4 5 6 7 8 9 10 

16. **What areas of the body have you had pain? (state all body parts below)**

.....

FATIGUE

Fatigue and tiredness can be a symptom as we use so much more energy to move.

17. **Are there changes in your energy levels (tiredness/fatigue) than usual in the last year?**

Yes ☐ No ☐

If Yes, please explain

.....

18. **Have you noticed reduced muscle strength than usual in the last year?**

Yes ☐ No ☐

If Yes, please explain

.....

19. **Do you find it more difficult to perform daily personal care e.g. dressing, and washing than usual in the last year?**

Yes ☐ No ☐

If Yes, please explain

.....

20. **Do you need additional time to perform activities of daily living than usual in the last year?**

Yes ☐ No ☐

If Yes, please explain

.....

21. **Do you take longer or more frequent rest periods to perform activities of daily living than usual in the last year?**

Yes ☐ No ☐

If Yes, please explain

.....

22. Do you take more support from others to perform activities of daily living than usual in the last year?

Yes ☐ No ☐

If Yes, please explain

.....

MOBILITY

Having CP can affect our muscle strength, mobility and balance.

23. Have you had BOTOX injections?

Yes ☐ No ☐ N/A ☐

If Yes, where and when?

.....

24. Are you still feeling the benefit of BOTOX injections?

Yes ☐ No ☐ N/A ☐

If No, when are you due for the next one?

.....

25. Do you use any mobility aid/equipment?

Yes ☐ No ☐

If Yes, which ones?

.....

26. Where do you use the mobility aids/equipment?

At home ☐ In the community ☐ N/A ☐

How often do you use?

.....

27. Have you noticed changes in your walking distance or need to use mobility aid more often than usual in the last year?

Yes ☐ No ☐ N/A ☐

If Yes, please explain

.....

28. Have you noticed a reduction in the balance in the last year?

Yes ☐ No ☐ N/A ☐

If Yes, please explain

.....

FALLS

If our mobility is affected it makes us more at risk of falls.

29. Are you falling more than usual?

Yes ☐ No ☐ N/A ☐

If Yes, please explain

.....

30. Have you become more aware of falls and are making decisions to mitigate the risk of falls? (e.g. using wheelchair instead of walking to prevent falls)

Yes ☐ No ☐ N/A ☐

If Yes, please explain

.....

31. How often do you fall in a week/month? (e.g. slips, trips, lost balance or landed on the floor)

.....

32. Have you had any serious injuries as a result of your falls in the last year?

Yes ☐ No ☐

If Yes, please explain

.....

SLEEP

Sleep problems can impact both physical and mental well-being.

33. Have you noticed changes in your sleep pattern in the last year?

Yes ☐ No ☐

If Yes, please explain

.....

34. Have you noticed changes in the quality of your sleep in the last year?

Yes ☐ No ☐

If Yes, please explain

.....

35. Have you had difficulty going to sleep?

Yes ☐ No ☐

If Yes, please explain

.....

36. Have you had difficulty staying in sleep?

Yes ☐ No ☐

If Yes, please explain

.....

37. Have you had difficulty getting up in the morning?

Yes ☐ No ☐

If Yes, please explain

.....

38. Are these different to your usual sleep?

Yes ☐ No ☐

If Yes, please explain

.....

39. Have you changed your medications to help manage your sleep in the last year?

Yes ☐ No ☐

If Yes, please explain

.....

MENTAL HEALTH

Research has shown there is a higher risk of mental health issues like anxiety and depression in our community.

40. Please tick symptoms/changes you have experienced in the last year:

Reduced ability to concentrate/easily distracted ☐

Reduced self-esteem/confidence ☐

Lowered stress tolerance threshold (more easily affected by stress) ☐

Anxiety (e.g.panic attacks, future concerns, worried) ☐

Depression (e.g. sad, angry, upset) ☐

Mood swings/ loneliness ☐

Used alcohol/smoking/drugs to cope with the above ☐

Others

.....

41. Do you have regular contacts with friends and families?

Yes ☐ No ☐

Others

.....

42. Are you connected with other people with CP in real life?

Yes ☐ No ☐

If No, would you like to be connected to other people with CP?

.....

43. Have you got video conferencing platform (e.g. Zoom, Skype) access to connect with other people?

Yes ☐ No ☐

If No, would you like to be connected to other people with CP via video call?

.....

WOMEN'S HEALTH

It is important to discuss women's health concerns with your doctor.

44. If you are eligible, do you go for a regular cervical smear test or mammogram screening?

Yes ☐ No ☐ N/A ☐

If No, what is the reason you haven't been for regular screening?

.....

45. Do you have issues with the menstrual cycle that you need to talk about? (e.g. using pads, spasms, medications)

Yes ☐ No ☐ N/A ☐

If Yes, have you discussed this with your GP or social worker or community nurse?

.....

46. Are you trying to become pregnant?

Yes ☐ No ☐ N/A ☐

If Yes, do you have any concerns that need to be discussed with your GP or social worker or community nurse?

.....

47. Do you have issues with menopause that you need to talk about (GP or community nurse)?

Yes ☐ No ☐ N/A ☐

MEN'S HEALTH

It is important to discuss men's health concerns with your doctor.

48. Do you have any issues that you need to talk about? (e.g. urinary incontinence, erectile dysfunction, prostate issues)

Yes ☐ No ☐ N/A ☐

If Yes, please explain

.....

49. Have you discussed this with your GP or community nurse?

Yes ☐ No ☐ N/A ☐

HEALTHY RELATIONSHIPS

Everyone is entitled to have healthy relationships.

50. Do you have any concerns about relationships or sex?

Yes ☐ No ☐

If Yes, what is your main concern or worry?

.....

51. What would be helpful to improve healthy relationships?

.....

SOCIAL LIFE

Connecting with other people is important for our sense of well-being.

52. Is your social life as active as you'd like?

Yes ☐ No ☐

If No, what else would you like to do?

.....

53. Are there any sports or hobbies or arts you'd like to take up or get better at?

Yes ☐ No ☐

If Yes, please explain:

.....

54. Are there things that you used to do that you cannot do now?

Yes ☐ No ☐

If Yes, please explain:

.....

55. Would you like to go back to doing your previous sport or hobby or art, if you could?

Yes ☐ No ☐

WHAT WOULD MAKE A DIFFERENCE TO YOUR WELLBEING?

Take a moment to look over your answers and think about how they directly affect your daily life. This could include things like pain, fatigue, stiffness, reduced mobility, falls, confidence, exercise, sports and hobbies.

56. Are there any specific tasks you find challenging?

Yes ☐ No ☐

If Yes, what are your main concerns?

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ONCE YOU HAVE COMPLETED THE ANNUAL SELF CHECK

If you are noticing changes in your functional ability then discuss this checklist with your GP along with the information leaflet. Your GP may check and refer if needed.