We are going to ask you a series of questions about your health and well-being, and your ability to take care of yourself and move around since your stroke. Some questions will also ask you about your preferences for care. The goal is to share this information with your doctors, nurses, and therapists so that they can develop a care plan made especially for you. Please answer the following questions on the state of your health or function and the activities you would prefer to do to help you recover and stay healthy.

1. Since you were hospitalized for your stroke, have you had enough money to buy your medicines and take them as your doctor prescribed?
   - Yes
   - No
   - No response

2. Do you know any of the risk factors that may lead to a stroke?  
   - Yes
   - No  ➔ Go to Question 3

   2a. What are these risk factors? (check all that apply)
   - High Blood Pressure
   - Smoking
   - Diabetes or High Blood Sugar
   - Irregular Heart Beat (Atrial Fibrillation)
   - Heart Disease
   - High Cholesterol
   - Physical Inactivity
   - Sickle Cell Anemia
   - Family History of Stroke
   - Prior Stroke
   - Response not on this list

   2b. Did the patient know any of the risk factors for stroke?
   - Yes
   - No
3. Compared to others your age, how would you rate your health since your stroke using a scale of 1 to 5, with 1 being “poor” and 5 being “excellent”?

   (1) Poor  (2) Fair  (3) Good  (4) Very Good  (5) Excellent  □ No response

4. Can you go up and down 10 stair steps without help?  □ Yes  □ No  □ No response

5. If your hand was affected by your stroke, how difficult is it to use your hand most affected by your stroke?

   (1) Cannot use at all  (2) Very difficult  (3) Somewhat difficult  (4) A little difficult  (5) Not difficult at all  □ No response

6. Have you fallen in the last 3 months?  □ Yes  □ No  → Go to Question 8

6a. In the last 3 months, did you get injured and need to go to the doctor or emergency department due to a fall?  □ Yes  □ No  □ No response

6b. Have you fallen more than once in the last 3 months?  □ Yes  □ No  □ No response

7. Have you fallen since your stroke?  □ Yes  □ No  → Go to Question 8

7a. How many times have you fallen since your stroke?  _________ □ Don’t know □ No response

8. Please continue this sequence: 1, A, 2, B, 3, C, _, _, _, _, _, ___.

   Choose “yes” if the patient completed the entire sequence correctly.

   □ Yes  □ No  □ No response

9. How many different medications do you take per day?  _____________ □ Don’t know □ No response

10. Is there someone to help you move about, bathe, dress, etc. for 30 days if you ever need assistance?  □ Yes  □ No  → Go to Question 11

10a. What relationship is he/she to you?

   □ Spouse
   □ Sibling
   □ Son/Daughter
   □ Neighbor/Friend
   □ Parent/Legal Guardian
   □ Other (Specify)  → Specify other in 10b
   □ No response

10b. Specify other:  _____________
11. Since your stroke, have you often been bothered by feeling down, depressed, or hopeless?
☐ Yes  ☐ No  ☐ No response

12. Since your stroke, have you often been bothered by little interest or pleasure in doing things?
☐ Yes  ☐ No  ☐ No response

If the following criteria are met:
- Question 1: Yes
- Question 2: Yes or No
- Question 2b: Yes or No
- Question 3: (3) Good or (4) Very Good or (5) Excellent
- Question 4: Yes
- Question 5: (4) A little difficult or (5) Not difficult at all
- Question 6: No
- Question 8: Yes
- Question 9: 4 or less
- Question 10: Yes
- Question 11: No
- Question 12: No

Only the following questions will be asked:
- Question 14
- Question 26-27
- Question 34-38
- Question 42-43
- Question 47

If the above criteria are met, BUT
- Question 11: Yes
- OR
- Question 12: Yes

Only the following questions will be asked:
- Question 14
- Question 26-27
- Question 34-38
- Question 40-41
- Question 42-43
- Question 47

13. Over the next 3 months, do you think your health is going to:
☐ Improve  ☐ Stay the same  ☐ Get worse  ☐ No response

14. What are your primary reasons for staying as healthy as you can?
(Open-ended question)

For example,

<table>
<thead>
<tr>
<th>Reason</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work – return to work</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Social – visit with friends, go out, and/or travel</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Family – visit with family, play with my grandchildren</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Independence – be independent, take care of myself</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Better quality of life</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other ⇒ Specify other in 14b</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>No response</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14b. Specify other ____________
These next few questions ask about your ability to take care of yourself and move around.

15. Can you walk for at least 15 minutes without getting short of breath or needing to stop and rest?
   □ Yes     □ No    □ No response

16. Can you walk without feeling unsteady?
   □ Yes     □ No    □ No response

17. Can you get up out of a chair **without** using your hands?
   □ Yes     □ No    □ No response

18. Can you use the phone to call your family or doctor if needed?
   □ Yes     □ No    □ No response

19. Can you prepare your own meals or do your own housework without any assistance?
   □ Yes     □ No    □ No response

20. Can you bathe/take a shower and dress yourself without any assistance?
   □ Yes     □ No    □ No response

21. Are you having trouble controlling your bladder or bowels?
   □ Yes     □ No    □ No response

**Because ability to remember is so important for managing your health, I am going to ask a few questions about this area of your life. There really is no right or wrong answer. These are helpful questions to assist your doctors and nurses to help you have the assistance you need to manage your health.**

22. Can you tell me the day of the week, month, and year? (Choose “Yes” if the patient was able to correctly identify day of the week, month, and year.)
   □ Yes     □ No    □ No response

I am going to read a list of words to you that you will have to remember. Please listen carefully. When I am through, repeat as many words as you can remember. It doesn’t matter in what order you say them.

   Trial 1: School, blue, apple.

I am going to read the list for a second time. Repeat as many words as you can.

   Trial 2: School, blue, apple.

I will ask you to recall these words again later on in this assessment.

23. Tell me why you are taking two of your medicines. (Choose “Yes” if patient was able to recall two medicines and reasons for taking them).
   □ Yes     □ No    □ No response
24. Does anyone help you manage your medications? (Puts your medicine in a pill box, hands your medicines to you, etc.).
   - Yes
   - No
   - No response

25. In the last month, were you unable to buy your medicines because of not having enough money?
   - Yes
   - No
   - No response

26. Do you stop taking your medicine if you feel better or worse?
   - Yes
   - No
   - No response

27. Do you ever forget to take your medicine?
   - Often
   - Sometimes
   - Rarely
   - Never
   - No response

28. Please recall the three words I asked you to remember. It doesn’t matter in what order you list them.
   (Choose “Yes” if patient was able to recall all 3 words: school, blue, apple).
   - Yes
   - No
   - No response

29. Since your stroke, do you eat at least two meals a day?
   - Yes
   - No
   - No response

30. Since your stroke, have you had new problems swallowing or chewing your food?
   - Yes
   - No
   - No response

31. Since your stroke, have you had increased stiffness in your hand, arm, or leg that interferes with your activities of daily living?
   - Yes
   - No
   - No response

32. Since your stroke, have you been able to drive yourself to and from places?
   - Yes
   - No
   - No response

33. If unable to drive, is there someone who can take you to the doctor or pharmacy?
   - Yes
   - No
   - No response

34. Do you have one doctor that knows you and all of your medical conditions?
   - Yes
   - No → Go to Question 39

35. What is the doctor’s first and last Name? ________________
   - Don’t know
   - No response

36. Have you seen him/her in the past 3 months?
   - Yes
   - No → Go to Question 38

37. Have you seen him/her since your stroke?
   - Yes
   - No
   - No response

38. In the past 3 months, did you miss any scheduled appointments with this doctor?
   - Yes
   - No
   - No response
39. Do you have a network of family and friends who visit you as often as you like?
   □ No, I am often lonely
   □ Yes, I can count on my family and friends to lean on when I feel down
   □ No response

40. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?
   □ Yes □ No □ No response

41. Since your stroke, has your relationship with your family become more difficult or stressed?
   □ Yes □ No □ No response

42. In the last 3 months, with the exception of your stroke, how many times were you seen in the emergency department?
   ___________________ □ Don’t know □ No response

43. How many times in the last 3 months have you been hospitalized overnight, with the exception of your hospitalization due to your stroke?
   ___________________ □ Don’t know □ No response

44. What home health services are you currently receiving?
   (Open-ended question)

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>None → Go to Question 45</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Speech &amp; Language Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care Assistant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No response → Go to Question 45</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

45. What type of outpatient therapy are you currently receiving?
   (Open-ended question)

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech &amp; Language Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
46. What Durable Medical Equipment (DME) are you currently using?  
(Open-ended question)

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cane</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Wheelchair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bath Safety Equipment (Toilet rails/frames, shower bench/seat)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bedside Commode</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No response</td>
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<td></td>
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</tbody>
</table>

47. What is the best way to reach you to discuss your health and how you are doing?

- [ ] Telephone call → If checked, answer 47a  
- [ ] Text message → If checked, answer 47a  
- [ ] Email → If checked, answer 47b  
- [ ] I will visit My Health portal on the internet  
- [ ] No response

a. What is the best number to reach you? ____________________  
   - [ ] Don’t know  
   - [ ] No response

b. What is your email address? ____________________  
   - [ ] Don’t know  
   - [ ] No response

Your doctors and nurses want to take good care of you and respect your values and views. They want to make sure they understand your views on treatment so they can take good care of you. Because unexpected things can happen, you have the right to make decisions about your healthcare. This includes the right to accept or refuse medical or surgical treatment when you are seriously ill or lose the ability to participate in decision-making about your own treatment. Fortunately, you have the right to plan and direct the types of healthcare and life sustaining treatments you wish to receive in the future. You can do this by making an advance directive (living will). An advance directive gives you a voice in decisions about your medical care.

48. Do you have a living will?  
   - [ ] Yes → Go to Question 49  
   - [ ] No

48a. Would you be interested in information to assist you in creating a living will?  
   - [ ] Yes  
   - [ ] No  
   - [ ] No response

49. Did someone other than the patient answer the majority of these questions?  
   - [ ] Yes  
   - [ ] No

49a. What was their relationship to the patient?  
   - [ ] Spouse  
   - [ ] Sibling  
   - [ ] Son/Daughter  
   - [ ] Neighbor/Friend  
   - [ ] Parent/Legal Guardian  
   - [ ] Other (Specify) → Specify other in 49b  
   - [ ] No response

49b. Specify other: ____________
Based on your answers, we have found the following [Summarize to patient results from the questionnaire].

What support/services do you have to help you? And what resources would you like to receive in order to help you?

Thank you for responding to our questions. I am going to discuss your questionnaire with the provider (nurse practitioner/physician assistant/physician) and use your responses to arrange any services that will be useful to ensure the best possible stroke recovery. Do you have any questions for me?

To be completed by the interviewer. Which of the following factors do you think this patient will need help or assistance with to speed their stroke recovery?

☐ Activities of Daily Living (bathing, dressing, walking)
☐ Exercise to improve strength, balance, and endurance
☐ Falls prevention
☐ Durable medical equipment or home modifications
☐ Transportation to follow-up appointments
☐ Manage medications (pill box, etc.)
☐ Monitor/control of stroke risk factors (blood pressure, hypertension)
☐ Pharmacy referral
☐ Financial assistance to purchase medications
☐ Depression services, treatment, and support
☐ Patient doesn’t have a primary care physician & needs help getting one
☐ Identify caregiver to assist & be available during instructions
☐ Refer to Outpatient Therapy (PT/OT)
☐ Refer to Speech and Language Therapy (SLP)
☐ Refer to Home Health Services
☐ Refer to Skilled Nursing Home
☐ Refer to Community Services
☐ Assistance with Advance Directive
☐ Nutritional support
☐ None

Thank you!
Thanks for completing this questionnaire!
Go out and live the best day possible.
You deserve it.

END OF POST STROKE FUNCTIONAL ASSESSMENT