

QUESTIONNAIRE FOR PATIENTS WITH STROKE

1. **When did you have your stroke** (please provide as accurate a date as possible).....

2. **What type of stroke did you have?** (please circle)

- A. Blockage/infarct
- B. bleed
- C. I do not know

3. **Which hospital were you admitted to?**

4. **Have you ever had another stroke?** (please circle)

- A. No
- B. Yes
- C. I am not sure

5. **Have you ever had a fit or have taken medication for fits in your life (even as a child)?**

- A. yes
- B. No

7. **Do you have any metal parts in your head/body?** (you can tick more than one boxes)

- A. pacemaker
- B. metallic implants in the ears
- C. metallic eye injuries
- D. clips from head surgery
- E. shrapnel to gunshot injuries
- F. None of the above

8. **Do you have any other medical problems apart from the stroke?** (you can tick more than one)

- Irregular heart beat
- Psychiatric problems
- High blood pressure
- Chest pain or heart attack
- Diabetes
- Blood clotting problems
- Other Neurological problems (please describe).....
- Other general medical problems (please describe).....
- No other problem apart from the stroke

9. **Can you please list the medication you are currently taking?**

10. What type of problems had you early after your stroke (during the first weeks or month)? (you can tick more than one box)

- | | |
|---|---|
| <input type="checkbox"/> A. Arm/ hand weakness | <input type="checkbox"/> G. Swallowing difficulties |
| <input type="checkbox"/> B. Leg weakness | <input type="checkbox"/> H. Double vision |
| <input type="checkbox"/> C. Numbness or loss of sensation
in arm/leg | <input type="checkbox"/> I. Other problems with my eyesight,
but not double vision |
| <input type="checkbox"/> D. Difficulty in finding the right words | <input type="checkbox"/> K. Mainly dizziness and balance
problems without real weakness in the
arm or leg |
| <input type="checkbox"/> E. Difficulty in understanding others | |
| <input type="checkbox"/> F. Only slurred speech | |

11. What type of problems do you have now? (you can tick more than one box)

- | | |
|---|---|
| <input type="checkbox"/> A. Arm/ hand weakness | <input type="checkbox"/> G. Swallowing difficulties |
| <input type="checkbox"/> B. Leg weakness | <input type="checkbox"/> H. Double vision |
| <input type="checkbox"/> C. Numbness or loss of sensation
in arm/leg | <input type="checkbox"/> I. Other problems with my eyesight,
but not double vision |
| <input type="checkbox"/> D. Difficulty in finding the right words | <input type="checkbox"/> K. Mainly Dizziness and balance
problems without real weakness in the
arm or leg |
| <input type="checkbox"/> E. Difficulty in understanding others | |
| <input type="checkbox"/> F. Only slurred speech | |

12. If you have weakness in your arm:

How much can you move your shoulder now? (please circle)

- | | |
|--|--|
| A. Not at all | B. I can reach forward (e.g. to pick up a glass) |
| C. I can raise my arm to shoulder height | D. I can put my hand behind my head |

How much can you move your elbow now? (please circle)

- | | |
|------------------------------------|---|
| A. Not at all | B. I can raise my forearm, but cannot bring my hand to my mouth |
| C. I can bring my hand to my mouth | |

12. If you have some weakness in your hand:

Please tick which of the following describes more what you can do with your weak hand now:

- A. I can grip and let go, but my hand is weaker than the other side
 B. I can grip, but it needs time to let go
 C. I can grip but cannot let go without help
 D. I need a splint to keep my hand open

Can you pick up small things using your first two fingers? (you can tick more than one)

- A. I can pick up a penny B. I can pick up a pen C. I can pick up a mobile phone

Can you make a phone call? (please circle)

- A. I cannot pick up the receiver B. I can pick up the receiver but cannot dial the number
C. I can pick up the receiver and dial the number

Can you use knife and fork to eat? (please circle)

- A. Yes B. No C. yes, but with much difficulty, or very slowly

Can you use your weak hand to hold things down, e.g. to chop vegetables or slice bread? (please circle)

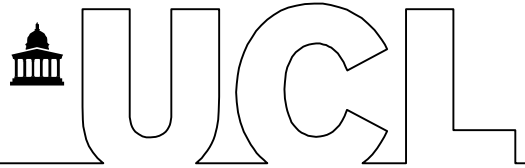
- A. Yes B. No C. yes, but with much difficulty, or very slowly

Can you use your weak hand to lift a cup of coffee or tea? (please circle)

- A. Yes B. No C. yes, but with much difficulty, or very slowly

Do you have a problem with shoulder pain?

- A. No B. A little, but I can handle it with few or no painkillers C. I have severe pain



Study title: Enhancing the effect of physical therapy for motor impairment after stroke with Theta Burst Stimulation (TBS).

Are you happy for us to write to your GP to

a) inform him that you are interested to participate in the study?

A. Yes

B. No

C. Send me more information first

b) request more information about your stroke?

A. Yes

B. No

C. Send me more information first

GP contact details

NAME:

ADDRESS:

Your contact details

NAME:

ADDRESS:

TELEPHONE:

Print name

Signature

Date

**Name of the person
signing**
(if other than yourself)

Signature

Date