Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *y y y y* *m m* d d

Participant Baseline Information Form-pg. 1

1. Interviewer's Initials: ☐☐

2. Gender: ☐ Male ☐ Female

Height: ☐☐☐

Weight: ☐☐☐

Waist Circumference: ☐☐☐

3. Date of Birth: ☐☐☐☐ ☐☐ ☐☐ *y y y y* *m m* **d d**

4. Date of Stroke: ☐☐☐☐ ☐☐ ☐☐ *y y y y* *m m* **d d**

5. Rehab Admission Date: ☐☐☐☐ ☐☐ ☐☐ *y y y y* *m m* **d d**

6. Brain Hemisphere Affected: ☐ R ☐ L

7. Limb (s) Affected: ☐ UE ☐ LE

8. Dominant Hand (prior to stroke): ☐ R ☐ L

9. Recurrent Stroke: ☐ Yes ☐ No

If yes, same side?: ☐ Yes ☐ No

How many times?: ☐☐

Subject ID: ☐☐ (Centre) ☐☐☐ (Patient ID) **Visit Date:** ☐☐☐☐ (yyyy) ☐☐ (mm) ☐☐ (dd)

Participant Baseline Information—pg.2

11. Pre-Stroke Disability: (Modified Rankin Scale) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

12. Stroke Information Obtained from: ☐ CT ☐ MRI

13. Stroke Type: ☐ Lacunar ☐ Infarct ☐ Hemhorrhagic ☐ Unknown

14. Stroke Location: ☐ Cortical ☐ Subcortical ☐ Unknown

15. Vessel Affected: ☐ MCA ☐ ACA ☐ PCA

☐ Other, please specify_____

16. Diabetes mellitus: ☐ Yes ☐ No

If yes, criteria: (check all that apply)
- ☐ Self-reported
- ☐ Taking antidiabetic medication
- ☐ Elevated glucose in medical records

17. Hypertension: ☐ Yes ☐ No

If yes, criteria: (check all that apply)
- ☐ Self-reported
- ☐ Taking a medication specifically for lowering BP
- ☐ High blood pressures in medical records
- ☐ History of hypertension in medical records

18. Current Medication:_____

_____

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

Participant Baseline Information—pg. 3

19. Tobacco use:

☐ Never smoked

☐ Former smoker ----> Year stopped: ☐☐☐☐

Years smoked: ☐☐

,

Average cigarettes per day: ☐☐☐ and/or ☐ pipes/cigars

☐ Current smoker-----> Year stopped: ☐☐☐☐

Years smoked: ☐☐

Average cigarettes per day: ☐☐☐ and/or ☐ pipes/cigars

20. Years of Formal Education: (high school = 12 years, add years post-secondary) ☐☐

21. Spoken Language preference:

☐ English (>90%) ☐ Chinese (>90%) ☐ French (>90%)

☐ Other (>90%)_____

22. Two languages spoken regularly at home which >50% of time?

☐ English (>90%) ☐ Chinese (>90%) ☐ French (>90%)

☐ Other (>90%)_____

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

Participant Baseline Information—pg. 4

22. Ethnicity:

☐ White (Caucasian)

☐ Aboriginal (First Nations person, Metis, Inuit)

☐ Black

☐ Latin American

☐ South Asian (East Indian, Pakistani, Sri Lankan, etc.)

☐ East Asian (Chinese, Vietnamese, Filipino, Korean, etc.)

☐ More than one or other: _____

23. Marital Status:

☐ Never married

☐ Married/Common Law

☐ Separated/Divorced

☐ Widowed

24. Living Arrangements (Prior to stroke):

☐ Alone in house or apartment

☐ With spouse/relatives/others in home or apartment

☐ Assisted living facility or nursing home or other paid caregiver

☐ Other

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

Participant Personal Information Form

*This form will not be entered into the database – it is kept for contact information for the 6 and 12 month follow up evaluations. This form will be stored in a locked filing cabinet at the study site where the participant is enrolled.

1. Participant Name:_____

2. Screening ID:_____

3. Assigned Study ID:_____

4. Date of Birth: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

5. Gender: ☐ Male ☐ Female

6. Patient Contact Phone Number: _____

7.Patient address: _____

8. Family/Friend contact: _____ Relation: _____

Phone number:_____

Address: _____

9. Medications:_____

_____

☐ *6M* ☐ *12M*

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

6 and 12 Month Follow Up Information Form

1. Interviewer's Initials: ☐☐

2.Patient address and contact phone number same as data on personal information form?: ☐ Yes ☐ No
(*If new address and/or phone number, make change on personal information form and date)*

3. Family/friend contact information same as data on personal information form?: ☐ Yes ☐ No
(If new information, make change on personal information form and date)

4. Any change in health/functional status since last evaluation?: ☐ Yes ☐ No

Comments:

_____

5. Any change in medications since last evaluation?: ☐ Yes ☐ No
*(*Interviewer compares meds to those on participant's baseline/6 month evaluation form)*

Comments:_____

6. Any change in living situation since last evaluation?: ☐ Yes ☐ No

Comments:_____

☐ 6M ☐ 12M

Subject ID: ☐☐ ☐☐☐ (Centre / Patient ID) **Visit Date:** ☐☐☐☐ ☐☐ ☐☐ (yyyy / mm / dd)

6 and 12 Month Follow Up Information Form-pg. 2

9. Any falls since last evaluation?: ☐ Yes ☐ No

Number of falls: ☐☐☐

If appropriate, list date(s) and reason(s) for falls:

☐☐☐☐ ☐☐ ☐☐ (yyyy mm dd) Reasons:_____

☐☐☐☐ ☐☐ ☐☐ (yyyy mm dd) Reasons:_____

☐☐☐☐ ☐☐ ☐☐ (yyyy mm dd) Reasons:_____

10. Any formal therapy received since last evaluation?: ☐ Yes ☐ No

(If appropriate list type of therapy/frequency/duration):

Type of therapy:_____ Duration:_____

Type of therapy:_____ Duration:_____

Type of therapy:_____ Duraiion:_____

11. Participation in any formal exercise/rehabilitation study since last evaluation?: ☐ Yes ☐ No

Comments:_____

_____

☐ *6M* ☐ *12M*

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

6 and 12 Month Step Activity Monitor Form

Evaluator's Initials: ☐☐

Note: Data obtained from the accelerometers that the participant wears for a 4 day period either before or after the 6 month and 12 month evaluation

Total number of steps:

☐☐ Day 1

☐☐ Day 2

☐☐ Day 3

☐☐ Day 4

Energy Expenditure:

☐☐ Day 1

☐☐ Day 2

☐☐ Day 3

☐☐ Day 4

☐ BL ☐ FU ☐ 6M ☐ 12M

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

Outcome Measures-5 Meter Walk Evaluation Form

1. Evaluator's Initials: ☐☐

5 Meter Walk Test

Time (in seconds) to walk 5 meters: ☐☐☐.☐☐ sec

"Comfortable" (Self-Selected)Pace): ☐☐☐.☐☐ sec

a) Trial 1: "Comfortable Pace" - Number of seconds: ☐☐☐.☐☐ sec

b) Trial 2: "Comfortable Pace" - Number of seconds: ☐☐☐.☐☐ sec

c) Assistive Devices: ☐ None ☐ Single point cane ☐ Quad cane ☐ Wheeled walker

☐ Standard ☐ Other:_____

d) Type of AFO: ☐ None ☐ Rigid Plastic (no joint) ☐ Rigid Plastic (with joint)

☐ Other:_____

e) FAC:

☐ Ambulator—Dependent for Physical Assistance Level II

☐ Ambulator—Dependent for Physical Assistance Level I

☐ Ambulator—Dependent for Supervision

☐ Ambulator—Dependent for Supervision

☐ Ambulator—Indendant, Level surfaces only

☐ Ambulator—Independant, Level and non-level surfaces

☐ *BL* ☐ *FU* ☐ *6M* ☐ *12M*

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

6 Minute Walk Evaluation Form

1. Evaluator's Initials: ☐☐

2. Height: ☐☐☐.☐ cm

3. Weight: ☐☐☐.☐ kg

4. Rest HR: ☐☐☐.☐

   Rest BP: ☐☐☐.☐

   Peak BP: ☐☐☐.☐

5. Distance covered in 6 minutes: ☐☐ Meters

☐ BL ☐ FU ☐ 6M ☐ 12M

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

Berg Balance Scale Evaluation Form-pg. 1

Evaluator's Initials: ☐☐

The Berg Balance Scale (BBS) is a 14-item scale to measure balance among people with impairment in balance function by assessing the performance of functional tasks in a clinical setting.

Equipment needed:
Ruler, bed and chair or two standard chairs, footstool or step, stopwatch or wristwatch.

Scoring:
A five-point scale, ranging from 0-4. "0" indicates the lowest level of function and "4" the highest level of function.
Total Score = 56

Instructions:

Grading: Please mark the category which applies.

1. Sitting to Standing from a chair
Instruction: Please stand up. Try not to use your hands for support.

☐ 4: Able to stand safely 2 minutes
☐ 3: Able to stand 2 minutes with supervision.
☐ 2: Able to stand 30 seconds unsupported.
☐ 1: Needs several tries to stand 30 seconds unsupported.
☐ 0: Unable to stand 30 seconds unassisted

2. Standing Unsupported
Instruction: Stand for two minutes without holding

☐ 4: Able to stand no hands and stablize independently
☐ 3: Able to stand independently using hands.
☐ 2: Able to stand using hands after several tries.
☐ 1: Needs minimal assistance to stand or to stabilize.
☐ 0: Unable to stand 30 seconds without assistance

☐ BL ☐ FU ☐ 6M ☐ 12M

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

Berg Balance Scale Evaluation Form-pg. 2

3. Sitting Unsupported Feet on Floor (do not test if patient is independent in standing or walking, just score 4)
Instruction: Sit with arms folded for two minute.

☐ 4: Able to sit safely and securely 2 minutes.
☐ 3: Able to sit 2 minutes under supervision.
☐ 2: Able to sit 30 seconds.
☐ 1: Able to sit 10 seconds.
☐ 0: Unable to sit without support 10 seconds

4. Standing to Sitting
Instruction: Please sit down.

☐ 4: Sits safely with minimal use of hands.
☐ 3: Controls descent by using hands.
☐ 2: Uses back of legs against chair to control descent.
☐ 1: Sits independently but has uncontrolled descent.
☐ 0: Needs assistance to sit.

5. Transfers
Instruction: Please move from chair to bed and back again. One way toward a seat with arm rests and one way toward a seat without arm rests. If a bed/plinth is used, it should be lowered and close to a chair seat height.

☐ 4: Able to transfer safely with minor use of hands.
☐ 3: Able to transfer safely definite need of hands.
☐ 2: Uses back of legs against chair to control descent.
☐ 1: Needs one person to assist.
☐ 0: Needs two people to assist or supervise to be safe.

☐ BL ☐ FU ☐ 6M ☐ 12M

Subject ID: ☐☐ ☐☐☐ (Centre / Patient ID) **Visit Date:** ☐☐☐☐ ☐☐ ☐☐ (yyyy / mm / dd)

Berg Balance Scale Evaluation Form-pg. 3

6. Standing Unsupported with Eyes Closed
Instruction: Close your eyes and stand still for 10 seconds.

☐ 4: Able to stand 10 seconds safely.
☐ 3: Able to stand 10 seconds with supervision.
☐ 2: Able to stand 3 seconds.
☐ 1: Unable to keep eyes closed 3 seconds but stays steady.
☐ 0: Needs two people to assist or supervise to be safe.

7. Standing Unsupported with Feet Together
Instruction: Place your feet together and stand without holding.

☐ 4: Able to place feet together independently and stand 1 minute safely.
☐ 3: Able to place feet together independently and stand for 1 minute with supervision.
☐ 2: Able to place feet together independently but unable to hold for 30 seconds.
☐ 1: Needs help to attain position but able to stand 15 seconds with feet together.
☐ 0: Needs help to attain position and unable to hold for 15 seconds.

8. Reaching Forward with Outstretched Arm
Instruction: Lift arm to 90 degrees. Stretch out your fingers and reach forward as far as you can. (Examiner places a ruler at end of fingertips when arm is at 90 degrees. Fingers should not touch the ruler while reaching forward. The recorded measure is the distance forward that the fingers reach while the subject is in the most forward lean position).
*

☐ 4: Can reach forward confidently more than 10 inches.
☐ 3: Can reach forward more than 5 inches safely.
☐ 2: Can reach forward more than 2 inches safely.
☐ 1: Reaches forward but needs supervision.
☐ 0: Needs help to keep from falling. _____inches

☐ BL ☐ FU ☐ 6M ☐ 12M

Subject ID: ☐☐ ☐☐☐ (Centre / Patient ID) **Visit Date:** ☐☐☐☐ ☐☐ ☐☐ (yyyy / mm / dd)

Berg Balance Scale Evaluation Form-pg. 4

9. Pick Up Object from the Floor
   Instruction: Pick up the shoe/slipper which is placed in front of your feet.

☐ 4: Able to pick up slipper safely and easily.

☐ 3: Able to pick up slipper but needs supervision.

☐ 2: Unable to pick up but reaches 1 to 2 inches from slipper and

☐ 1: Unable to pick up and needs supervision while trying.

☐ 0: Unable to try/needs assistance to keep from falling.

10. Turning to Look Behind Over Left and Right Shoulders
    Instruction: Turn to look behind you over toward left shoulder. Repeat to the right.
    Grading:

☐ 4: Looks behind from both sides and weight shifts well.

☐ 3: Looks behind one side only; other side shows less weight shift.

☐ 2: Turns sideways only but maintains balance.

☐ 1: Needs supervision when turning.

☐ 0: Needs assistance to keep from falling.

11. Turn 360 Degrees
    Instruction: Turn completely around in a full circle. Pause. Then turn a full circle in the other direction.

☐ 4: Able to turn 360 degrees safely in less than 4 seconds each side.

☐ 3: Able to turn 360 degrees safely one side only – less than 4 seconds.

☐ 2: Able to turn 360 degrees safely but slowly.

☐ 1: Needs close supervision or verbal cuing.

☐ 0: Needs assistance while turning.

☐ BL ☐ FU ☐ 6M ☐ 12M

Subject ID: ☐☐ ☐☐☐ (Centre / Patient ID) **Visit Date:** ☐☐☐☐ ☐☐ ☐☐ (yyyy / mm / dd)

Berg Balance Scale Evaluation Form-pg. 5

12. Step on Stool
Instruction: Place each foot alternately on the stool. Continue until each foot has touched the stool four times.

☐ 4: Able to stand independently and safely and complete 8 steps in 20 seconds.

☐ 3: Able to turn 360 degrees safely one side only – less than 4 seconds.

☐ 2: Able to complete 4 steps without aid with supervision.

☐ 1: Able to complete more than 2 steps – needs minimal assistance.

☐ 0: Needs assistance to keep from falling – unable to try.

13. Standing Unsupported One Foot in Front
Instruction: Place one foot directly in front of the other. If you feel that you cannot place your foot directly in front, try to step far enough ahead that the heel of your forward foot is ahead of the toes of the other foot. (DEMONSTRATE to subject.)

☐ 4: Able to turn 360 degrees safely in less than 4 seconds each side.

☐ 3: Able to place foot ahead of the other independently and hold 30 seconds.

☐ 2: Able to take small step independently and hold 30 seconds.

☐ 1: Needs help to step but can hold 15 seconds.

☐ 0: Loses balance while stepping or standing.

14. Standing on One Leg
Instruction: Stand on one leg (your stroke affected side) as long as you can without holding

☐ 4: Able to lift leg independently and hold more than 10 seconds.

☐ 3: Able to lift leg independently and hold 5 to 10 seconds.

☐ 2: Able to lift leg independently and hold at least 3 seconds.

☐ 1: Tries to lift leg, unable to hold 3 seconds but remains standing independently.

☐ 0: Unable to try or needs assistance to prevent fall.

TOTAL SCORE: ☐☐ /56

☐ *BL* ☐ *FU* ☐ *6M* ☐ *12M*

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *y y y y* *m m* d d

Isometric Knee Extension

1. Evaluator's Initials: ☐☐

Paretic lower extremity: ☐ R ☐ L _____newtons/kg

Non-paretic lower extremity: ☐ R ☐ L _____newtons/kg

☐ BL ☐ FU ☐ 6M ☐ 12M

Subject ID: ☐☐ ☐☐☐ (Centre, Patient ID) **Visit Date:** ☐☐☐☐ ☐☐ ☐☐ (yyyy, mm, dd)

EQ-5D Health Questionnaire

MOBILITY

I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE

I have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES *(e.g work, study, housework, family or leisure activities)*

I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN/DISCOMFORT

I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY/DISCOMFORT

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐

☐ BL ☐ FU ☐ 6M ☐ 12M

Subject ID: ☐☐ ☐☐☐ (Centre / Patient ID)

Visit Date: ☐☐☐☐ ☐☐ ☐☐ (yyyy / mm / dd)

Montreal Cognitive Assessment (MOCA)

Visuospatial/Executive:	☐☐/5
Naming:	☐☐/3
Attention:	☐☐/6
Serial Subtraction:	☐☐
Language:	☐☐/3
Abstraction:	☐☐/2
Delayed Recall:	☐☐/5
Orientation:	☐☐/6
Education:	☐☐
Total:	☐☐/30

☐ No data collected

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

NIH Stroke Scale-pg. 1

1a. Level of Consciousness

☐ 0 = Keenly responsive
☐ 1 = Not alert, but arousable by minor stimulation to obey, answer or respond
☐ 2 = Not alert, requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped)
☐ 3 = Responds only with reflex motor or autonomic effects or totally unresponsive, flacid

1b. LOC Questions

☐ 0 = Answers both questions correctly
☐ 1 = Answers one question correctly
☐ 2 = Answers neither question correctly

1c. LOC Commands

☐ 0 = Performs both tasks correctly
☐ 1 = Performs one task correctly
☐ 2 = Performs neither task correctly

2. Best Gaze

☐ 0 = Normal
☐ 1 = Partial gaze palsy. This score is given when gaze is abnormal in one or both eyes, but where forced deviation or total gaze paresis is not present.
☐ 2 = Forced deviation, or total gaze paresis not overcome by the occulocephalic maneuver.

3. Visual

☐ 0 = No visual loss
☐ 1 = Partial hemianopia
☐ 2 = Complete hemianopia
☐ 3 = Bilateral hemianopia (blind including cortical blindness)

4. Facial Palsy

☐ 0 = No drift, limb holds 90 (or 45) degrees for full 10 seconds
☐ 1 = Drift, limb holds 90 (or 45) degrees, but drifts down before full 10 seconds, does not hit bed
☐ 2 = Some effort against gravity, limb cannot get to or maintain (if cued) 90 degrees
☐ 3 = No effort against gravity, limb fails
☐ 4= No movement A=Amputation or joint fusion, explain:_____

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

NIH Stroke Scale-pg. 2

5. Motor Arm **R** **L**

☐ ☐ 0 = No drift, leg holds 30 degrees for full 5 seconds

☐ ☐ 1 = Drift, leg fails by the end of the 5 second period but does not hit bed

☐ ☐ 2 = Some effort against gravity, leg falls to bed by 5 secs, but has some effort against gravity

☐ ☐ 3 = No effort against gravity, leg falls to bed immediately

☐ ☐ 4 = No movement A = Amputation or joint fusion, explain:_____

6. Motor Leg **R** **L**

☐ ☐ 0 = No drift, leg holds 30 degrees for full 5 seconds

☐ ☐ 1 = Drift, leg fails by the end of the 5 second period but does not hit bed

☐ ☐ 2 = Some effort against gravity, leg falls to bed by 5 secs, but has some effort against gravity

☐ ☐ 3 = No effort against gravity, leg falls to bed immediately

☐ ☐ 4 = No movement A = Amputation or joint fusion, explain:_____

7. Limb Ataxia

☐ 0 = Absent

☐ 1 = Present in one limb

☐ 2 = Present in two limbs

If present check each limb yes or no:

Right arm: ☐ Yes ☐ No A=Amputation or joint fusion, explain: _____

Right Leg: ☐ Yes ☐ No A=Amputation or joint fusion, explain: _____

Left arm: ☐ Yes ☐ No A=Amputation or joint fusion, explain: _____

Left Leg: ☐ Yes ☐ No A=Amputation or joint fusion, explain: _____

8. Sensory

☐ 0 = Normal; no sensory loss.

☐ 1 = Mild to moderate sensory loss; patient feels pinprick is less sharp or is dull on the affected side; or there is a loss of superficial pain with pinprick but patient is aware

☐ 2 = Severe to total sensory loss; patient is not aware of being touched in the face, arm and leg

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

NIH-Stroke Scale-pg. 3

9. Best Language

- ☐ 0 = No aphasia, normal
- ☐ 1 = Mild to moderate aphasia: some obvious loss of fluency or facility of comprehension without significant limitation on ideas expressed
- ☐ 2 = Responds only with reflex motor or autonomic effects or totally unresponsive, flacid
- ☐ 3 = Mute, global aphasia: no usable speech or auditory comprehension

10. Dysarthria

- ☐ 0 = Normal
- ☐ 1 = Mild to moderate: slurs at least some words and at worst can be understood with some difficulty
- ☐ 2 = Severe: patient's speech is so slurred as to be unintelligible in the absence of or out proportion to any dysphasia, or is mute/anarthic
- ☐ 3 = UN=Intubated or any other physical barrier, explain:_____

11. Extinction and Inattention (Neglect)

- ☐ 0 = No abnormality
- ☐ 1 = Visual, tactile, auditory, spatial, or personal inattention or extinction to bilateral simultaneous simulation in one of the sensory modalities
- ☐ 2 = Profound hemi-inattention or hemi-inattention to more than one modality. Does not recognize own hand or orients to only one side of space

☐ BL ☐ FU

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

Functional Independence Measure (FIM)-pg. 1

	Score
Self-Care	
A. Eating	☐☐
B. Grooming	☐☐
C. Bathing	☐☐
D. Dressing - Upper Body	
E. Dressing - Lower Body	☐☐
F. Toileting	☐☐
Transfers	
G. Bladder Management	☐☐
H. Bowel Management	☐☐
Locomotion	
I. Bed, Chair, Wheelchair	☐☐
J. Toilet	☐☐
K. Tub, Shower	☐☐
Social Interaction	
L. Walk/Wheelchair	
M. Stairs	
Motor Subtotal Score:	☐☐☐

Subject ID: ☐☐ ☐☐☐
Centre *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐
yyyy *mm* dd

Functional Independence Measure (FIM)-pg. 2

Communication

N. Comprehension ☐☐

O. Expression ☐☐

P. Social Interaction ☐☐

Q. Problem Solving ☐☐

R. Memory ☐☐

Cognitive Subtotal Score: ☐☐☐

TOTAL FIM Score: ☐☐☐

☐ BL ☐ FU ☐ 6M ☐ 12M

Subject ID: ☐☐ ☐☐☐ (Centre, Patient ID) **Visit Date:** ☐☐☐☐ ☐☐ ☐☐ (yyyy, mm, dd)

Patient Health Questionnaire (PHQ-9)

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

10. If you checked off any problems (questions 1-9), how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not Difficult ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Subject ID: ☐☐ ☐☐☐ *Centre* *Patient ID*

Visit Date: ☐☐☐☐ ☐☐ ☐☐ *yyyy* *mm* dd

Godin Leisure Time Excercise Questionnaire

1. During a typical 7-Day period (a week), how many times on the average do you do the following kinds of exercise for more than 15 minutes during your free time
(write on each line the appropriate number). _____

2. STRENUOUS EXERCISE (HEART BEATS RAPIDLY)
squash, basketball, cross country skiing, judo, roller skating, vigorous swimming, vigorous long distance bicycling _____

3. MODERATE EXERCISE (NOT EXHAUSTING)
(e.g., fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular and folk dancing) _____

4. MILD EXERCISE (MINIMAL EFFORT)
(e.g., yoga, archery, fishing from river bank, bowling, horseshoes, golf, snow-mobiling, easy walking) _____

5. During a typical 7-Day period (a week), in your leisure time, how often do you engage in any regular activity long enough to work up a sweat (heart beats rapidly)?

☐ Often
7 Days/week

☐ Sometimes
2-4 Days/week

☐ Never/Rarely
0-1 Days/Week