



CRU-025-DOSE

Plate #001

Screening

Subject ID:

Centre

Patient ID

Visit Date:

y y y y

m m

d d

## Patient Screening Form

Interviewer's Initials:

(First/Last)

Participant Signed Consent Form:

☐

Yes

☐

No

Date of Consent:

y y y y

m m

d d

Gender:

☐

Male

☐

Female

Date of Birth:

y y y y

m m

d d

Confirmation that patient will be discharged to inpatient stroke rehab at DOSE study site?

☐

Yes

☐

No

Date Physiatry consult completed:

y y y y

m m

d d



CRU-025-DOSE

Plate #002

Screening

Subject ID:

Centre

Patient ID

Visit Date:

yyyy

mm

dd

## Inclusion & Exclusion Criteria

### Inclusion Criteria (All of the following **MUST** be Yes)

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Within 4 weeks post hemorrhagic or ischemic CVA with hemiparesis (confirmed by medical chart or motor assessment):        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Pre-stroke disability <2 (less than 2) on the Modified Rankin Scale.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Able to ambulate at least 15 feet (5 m distance). May use assistive and/or orthotic device and maximum one person assist. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Overground walking speed less than 1.0m/s (over a 5 m distance)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Able to understand and follow directions  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Greater than or equal to 19 years of age.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### Exclusion Criteria (All of the following **MUST** be No)

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Pre-stroke health included a gait disorder or disease that affected ambulation (musculoskeletal conditions, amputation, etc.)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Pre-stroke health included a neurological condition (such as Parkinson's disease or Multiple Sclerosis) or other serious medical condition (active cancer, uncontrolled diabetes) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Excessive pain in the body/joint preventing participation in an exercise intervention.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Participating in an experimental drug field study.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Participating in another formal exercise rehabilitation clinical trial.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



CRU-025-DOSE

Plate #003

Screening

Subject ID:

--	--

*Centre*

--	--	--

*Patient ID*

Visit Date:

--	--	--	--

*y y y y*

--	--

*m m*

--	--

*d d*

### Inclusion/Exclusion Continued

Participant meets study criteria and would like to proceed with study.

☐ Yes

☐ No

Participant meets study criteria, but does not want to proceed with study.

☐ Yes

☐ No

Comment: \_\_\_\_\_

Participant does not meet study criteria AT THIS TIME, but would like to be re-evaluated for the study in one week.

☐ Yes

☐ No

Comment: \_\_\_\_\_

Participant does not meet study criteria.

☐ Yes

☐ No

Comment: \_\_\_\_\_



CRU-025-DOSE

Plate #004

Screening

Subject ID:

Centre

Patient ID

Visit Date:

yyyy

mm

dd

**Participant Randomization Form**

1. Interviewer's Initials:

(First/Last)

2. Gender:

☐

Male

☐

Female

3. Date of Birth:

yyyy

mm

dd

4. FIM Transfer Status:

☐ $\geq 5$  (Greater than or equal to 5)☐

&lt; 5 (Less than 5)

5. Study Site:

☐

GF Strong

☐

Holy Family

☐

Fanning

☐

Foothills

☐

Toronto Rehab

6. Age:

☐ $\geq 60$  (Greater than or equal to 60)☐ $\leq 60$  (Less than 60)7. Meets all study inclusion criteria  
(Participant Screening Form):☐

Yes

☐

No

8. Randomization Date &amp; Time:

yyyy

mm

dd

hh

mm

**To be completed by DOSE Site Coordinator:**

ASSIGNED STUDY Group:

☐

Stroke Management Program

☐

Stroke Monitoring Program

☐

Stroke Supplementary Program

Initials of individual completing  
randomization:

(First/Last)

Date of randomization:

yyyy

mm

dd



CRU-025-DOSE

Plate #005

Baseline

Subject ID:

Centre

Patient ID

Visit Date:

yyyy

mm

dd

**Participant Baseline Information Form (pg. 1 of 4)**

1. Interviewer's Initials:

(First/Last)

2. Gender:

☐

Male

☐

Female

3. Height (cm):

cm

4. Weight (lbs):

lbs

5. Waist Circumference (cm):

cm

6. Date of Birth:

yyyy

mm

dd

7. Date of Stroke:

yyyy

mm

dd

8. Rehab Admission Date:

yyyy

mm

dd

9. Brain Hemisphere Affected:

☐

R

☐

L

10. Limb (s) Affected:

☐

UE

☐

LE

11. Dominant Hand (prior to stroke):

☐

R

☐

L

12. Recurrent Stroke:

☐

Yes

☐

No

If yes, same side?:

☐

Yes

☐

No

How many times?:



CRU-025-DOSE

Plate #006

Baseline

Subject ID:

Centre

Patient ID

Visit Date:

y y y y

m m

d d

**Participant Baseline Information (pg. 2 of 4)**

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 ☐ Hemorrhagic ☐ 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: \_\_\_\_\_
- \_\_\_\_\_



CRU-025-DOSE

Plate #007

Baseline

Subject ID:

Centre

Patient ID

Visit Date:

yyyy

mm

dd

**Participant Baseline Information (pg. 3 of 4)**19. Tobacco use: ☐ Never smoked☐ Former smoker:

Year stopped:

Years smoked:

Average cigarettes per day:

and/or ☐ pipes/cigars☐ Current smoker:

Years smoked:

Average cigarettes per day:

and/or ☐ pipes/cigars20. Years of Formal Education:  
(high school = 12 years,  
add years post-secondary)

21. Spoken Language preference:

☐ English☐ Chinese☐ French☐ Other \_\_\_\_\_22. If two languages spoken  
regularly at home, which is one  
is spoken >50% of time?☐ English☐ Chinese☐ French☐ Other \_\_\_\_\_



CRU-025-DOSE

Plate #008

Baseline

Subject ID:

*Centre*

*Patient ID*

Visit Date:

*y y y y*

*m m*

*d d*

## Participant Baseline Information (pg. 4 of 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: \_\_\_\_\_



## Baseline Visit #002

Subject ID:

--	--

*Centre*

--	--	--

*Patient ID*

Visit Date:

--	--	--	--

*y y y y*

--	--

*m m*

--	--

*d d*

### 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:

--	--	--	--

*y y y y*

--	--

*m m*

--	--

*d d*

5. Gender:

☐

Male

☐

Female

6. Patient Contact Phone Number: \_\_\_\_\_

7. Patient address: \_\_\_\_\_

8. Family/Friend contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

9. Medications: \_\_\_\_\_

\_\_\_\_\_



☐ *BL*   ☐ *FU*   ☐ *6M*   ☐ *12M*

CRU-DOSE-025

Plate #010

Subject ID:

*Centre*

*Patient ID*

Visit Date:

*y y y y*

*m m*

*d d*

## 6 Minute Walk Evaluation Form (pg. 1 of 2)

1. Evaluator's Initials:

(First/Last)

2. Height:

cm

3. Weight:

kg

4. Rest HR:

Peak HR:

Rest BP:

Peak BP:

5. Distance covered in 6 minutes:

m

| | | ■ ■ | | ■ | | | | | ■ | ■ ■ ☐ BL ☐ FU ☐ 6M ☐ 12M

CRU-025-DOSE

Plate #011

Subject ID:

Centre

Patient ID

Visit Date:

y y y y

m m

d d

## 6 Minute Walk Evaluation Form (pg. 2 of 2)

6. Assistive Devices:

☐

None

☐

Single point cane

☐

Quad cane

☐

Wheeled walker

☐

Standard walker

☐

Other: \_\_\_\_\_

7. Type of AFO:

☐

None

☐

Rigid Plastic (no joint)

☐

Rigid Plastic (with joint)

☐

Other: \_\_\_\_\_

8. FAC:

☐

Ambulator—Dependent for Physical Assistance Level II

☐

Ambulator—Dependent for Physical Assistance Level I

☐

Ambulator—Dependent for Supervision

☐

Ambulator—Independent, Level surfaces only

☐

Ambulator—Independent, Level and non-level surfaces



[illegible]

## Berg Balance Scale Evaluation Form (pg. 2 of 5)

#### 4. Standing to Sitting

*Instructions: 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

*Instructions: Arrange chair(s) for a pivot transfer. Ask the participant to transfer one way toward a seat with armrests and one way toward a seat without armrests. You may use two chairs (one with and one without armrests) or a bed and a chair. If bed/plinth is used, it should be chair height.*

- ☐ 4: Able to transfer safely with minor use of hands.
- ☐ 3: Able to transfer safely definite need of hands.
- ☐ 2: Able to transfer with verbal cueing and/or supervision.
- ☐ 1: Needs one person to assist.
- ☐ 0: Needs two people to assist or supervise to be safe.

## 6. Standing Unsupported with Eyes Closed

*Instructions: Please 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 help to keep from falling.

## 7. Standing Unsupported with Feet Together

*Instructions: Please 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.







| | | ■ ■ | | ■ | | | | ■ | | | | ☐ BL ☐ FU ☐ 6M ☐ 12M

CRU-025-DOSE

Plate #016

Subject ID:

--	--

Centre

--	--	--

Patient ID

Visit Date:

--	--	--	--

y y y y

--	--

m m

--	--

d d

## Berg Balance Scale Evaluation Form (pg. 5 of 5)

### 14. Standing on One Leg

*Instructions: Please stand on one leg 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

CRU-025-DOSE

Plate #018

Subject ID:

  
Centre  
Patient ID

Visit Date:

  
y y y y  
m m  
d d

## EQ-5D Health Questionnaire (pg. 1 of 2)

### PART A:

Instructions: Under each heading, please tick ONE box that best describes your health TODAY.

#### 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



☐ *BL* ☐ *FU* ☐ *6M* ☐ *12M*

CRU-025-DOSE

Plate #020

Subject ID:

  
*Centre*  
*Patient ID*

Visit Date:

  
*y y y y*  
*m m*  
*d d*

## Montreal Cognitive Assessment (MOCA)

Visuospatial/Executive:

  
/5

Naming:

  
/3

Attention:

Digits:

  
/2

Letters:

  
/1

Serial Subtraction:

  
/3

Language:

Repeat:

  
/2

Fluency:

  
/1

Abstraction:

  
/2

Delayed Recall:

  
/5

Orientation:

  
/6

Education:

(add 1 point if  $\leq 12$  years)

TOTAL SCORE:

  
/30

Expressive Aphasia:

☐ Yes☐ No

Expressive Aphasia Score:

  
/30

☐ *BL* ☐ *FU* ☐ *6M* ☐ *12M*

CRU-025-DOSE

Plate #021

Subject ID:

*Centre*

*Patient ID*

Visit Date:

*y y y y*

*m m*

*d d*

## Digit Symbol Substitution Test (DSST)

1. Evaluation Date:

*y y y y*

*m m*

*d d*

2. Evaluator's Initials:

(First/Last)

3. DSST Results:

Number of **correct** symbols in 1 minute

Number of **incorrect** symbols in 1 minute

☐ BL ☐ FU ☐ 6M ☐ 12M

CRU-025-DOSE

Plate #022

Subject ID:

Centre

Patient ID

Visit Date:

yyyy

mm

dd

## Trail Making A and B Data Form

1. Evaluation Date:

yyyy

mm

dd

2. Evaluator's Initials:

(First/Last)

TRAIL

Time (Seconds)

Number of Errors

A

B



CRU-025-DOSE

Plate #023

Baseline

Subject ID:

Centre

Patient ID

Visit Date:

y y y y

m m

d d

## NIH Stroke Scale (pg. 1 of 3)

### 1a. Level of Consciousness

- ☐ 0 = **Alert, 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 and areflexic.

### 1b. Level of Consciousness Questions

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

### 1c. Level of Consciousness Questions

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

### 2. Best Gaze

- ☐ 0 = **Normal**
- ☐ 1 = **Partial gaze palsy**; 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 = **Normal** symmetrical movements
- ☐ 1 = **Minor paralysis**; Flattened nasolabial fold, asymmetry on smiling)
- ☐ 2 = **Partial paralysis** (total or near-total paralysis of lower face)
- ☐ 3 = **Complete paralysis** of one or both sides (absence of facial movement in the upper and lower face).





CRU-025-DOSE

Plate #024

Baseline

Subject ID:

Centre

Patient ID

Visit Date:

yyyy

mm

dd

## NIH Stroke Scale (pg. 2 of 3)

## 5. Motor Arm

R L

0 = **No drift**; limb holds 45 degrees (or 90) for full 10 seconds1 = **Drift**; limb holds 45 degrees (or 90), but drifts down before full 10 seconds; does not hit bed or other support.2 = **Some effort against gravity**; limb cannot get to or maintain (if cued) 45 degrees (or 90), drifts down before full 10 seconds; does not hit bed or other support.3 = **No effort against gravity**; limb falls4 = **No movement**5 = **Amputation or joint fusion**, explain: \_\_\_\_\_

Non-Paretic UE Score:

Paretic UE Score:

## 6. Motor Leg

R L

0 = **No drift**; leg holds 30 degree position for full 5 seconds1 = **Drift**; leg falls by the end of the 5 second period, but does not hit the bed2 = **Some effort against gravity**; leg falls to bed by 5 secs, but has some effort against gravity3 = **No effort against gravity**; leg falls to bed immediately4 = **No movement**5 = **Amputation or joint fusion**, explain: \_\_\_\_\_

## 7. Limb Ataxia

0 = **Absent**1 = **Present in one limb**2 = **Present in two limbs**

UN: Amputation or joint fusion, explain: \_\_\_\_\_

## 8. Sensory

0 = **Normal**; no sensory loss1 = **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 of being touched.2 = **Severe to total sensory loss**; patient is not aware of being touched in the face, arm, and leg



CRU-025-DOSE

Plate #025

Baseline

Subject ID:

--	--

Centre

--	--	--

Patient ID

Visit Date:

--	--	--	--

y y y y

--	--

m m

--	--

d d

**NIH-Stroke Scale (pg. 3 of 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 or form of expression. Reduction of speech and/or comprehension, however, makes conversation about provided materials difficult or impossible. For example, in conversation about provided materials, examiner can identify picture or naming card content from patient's response.
- ☐ 2 = **Severe aphasia**; all communication is through fragmentary expression; great need for inference, questioning, and guessing by the listener. Range of information that can be exchanged is limited; listener carries burden of communication. Examiner cannot identify materials provided from patient response

**10. Dysarthria**

- ☐ 0 = **Normal**
- ☐ 1 = **Mild to moderate Dysarthria**; patient slurs at least some words and at worst, can be understood with some difficulty.
- ☐ 2 = **Severe dysarthria**; patient's speech is so slurred as to be unintelligible in the absence of or out of proportion to any dysphasia, or is mute/anarthic.

**11. Extinction and Inattention (formerly Neglect)**

- ☐ 0 = **No abnormality**
- ☐ 1 = **Visual, tactile, auditory, spatial, or personal inattention**, or extinction to bilateral simultaneous stimulation 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

Total Score:

--	--	--



CRU-DOSE-025

Plate #026

Subject ID:

Centre

Patient ID

Visit Date:

yyyy

mm

dd

## Functional Independence Measure (FIM) (pg. 1 of 2)

### Self-Care

### Score

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

**Motor Subtotal Score:**



☐ BL    ☐ FU    ☐ 6M    ☐ 12M

CRU-025-DOSE

Plate #028

Subject ID:

 

Centre

  

Patient ID

Visit Date:

   

yyyy

 

mm

 

dd

### Patient Health Questionnaire (PHQ-9)

	Not At All (0)	Several Days (1)	More Than Half the Days (2)	Nearly Every Day (3)
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**TOTAL:**

  

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



CRU-025-DOSE

Plate #029

Baseline

Subject ID:

Centre

Patient ID

Visit Date:

y y y y

m m

d d

## Godin Leisure Time Exercise Questionnaire

1. During a typical **7-Day period** (a week) before your stroke, 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).

Times Per Week

**a) STRENUOUS EXERCISE (HEART BEATS RAPIDLY)**

(e.g., squash, basketball, cross country skiing, judo, roller skating, vigorous swimming, vigorous long distance bicycling)

**b) MODERATE EXERCISE (NOT EXHAUSTING)**

(e.g., fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular and folk dancing)

**c) MILD EXERCISE (MINIMAL EFFORT)**

(e.g., yoga, archery, fishing from river bank, bowling, horseshoes, golf, snow-mobiling, easy walking)

TOTAL Leisure Activity Score:

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

☐ Often  
5-7 days/week

☐ Sometimes  
2-4 days/week

☐ Never/Rarely  
0-1 days/week



CRU-025-DOSE

Plate #030

Subject ID:

Centre

Patient ID

Visit Date:

yyyy

mm

dd

## 6 and 12 Month Follow Up Information Form (pg. 1 of 2)

1. Interviewer's Initials:

(First/Last)

2. Patient address and contact phone number same as data on personal information form?:

*(If new address and/or phone number, make change on personal information form and date)*

☐ Yes

☐ No

3. Family/friend contact information same as data on personal information form?:

*(If new information, make change on personal information form and date)*

☐ Yes

☐ No

4. Any change in health/functional status since last evaluation?:

☐ Yes

☐ No

Comments:

---

5. Any change in medications since last evaluation?:

*(\*Interviewer compares meds to those on participant's baseline/6 month evaluation form)*

☐ Yes

☐ No

Comments: 

---

6. Any change in living situation since last evaluation?:

☐ Yes

☐ No

Comments: 

---

☐ 6M ☐ 12M

CRU-025-DOSE

Plate #031

Subject ID:

Centre

Patient ID

Visit Date:

y y y y

m m

d d

## 6 and 12 Month Follow Up Information Form (pg. 2 of 2)

7. Any falls since last evaluation?:

☐ Yes

☐ No

Number of falls:

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

y y y y

m m

d d

Reasons: \_\_\_\_\_

y y y y

m m

d d

Reasons: \_\_\_\_\_

y y y y

m m

d d

Reasons: \_\_\_\_\_

8. 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: \_\_\_\_\_ Duraion: \_\_\_\_\_

9. Participation in any formal exercise/rehabilitation study since last evaluation?:

☐ Yes

☐ No

Comments: \_\_\_\_\_

\_\_\_\_\_



