



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	<input type="checkbox"/>
Medical history	<input type="checkbox"/>
Physical activity	<input type="checkbox"/>
Pain	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>
Mobility	<input type="checkbox"/>
Falls	<input type="checkbox"/>
Sleep	<input type="checkbox"/>
Mental health	<input type="checkbox"/>
Men's Health / Women's health	<input type="checkbox"/>
Relationships & Social Life	<input type="checkbox"/>

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).

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

Cancer

Lung condition

Heart condition

Obesity

Stroke

Liver disease

Arthritis/
joint pain

Osteoporosis

Muscle pain

Stomach
problems

Diabetes

Kidney disease

Other

PERSONAL HISTORY

Cancer

Lung condition

Heart condition

Obesity

Stroke

Liver disease

Arthritis/
joint pain

Osteoporosis

Muscle pain

Stomach
problems

Diabetes

Kidney disease

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	<input type="checkbox"/>	Horse riding	<input type="checkbox"/>	Gym/strength	<input type="checkbox"/>	Gardening	<input type="checkbox"/>
Adapted cycling	<input type="checkbox"/>	Dancing	<input type="checkbox"/>	Stretching	<input type="checkbox"/>	Hoovering	<input type="checkbox"/>
Swimming	<input type="checkbox"/>	Taichi	<input type="checkbox"/>	Boccia	<input type="checkbox"/>	Dish washing	<input type="checkbox"/>
Race running	<input type="checkbox"/>	Pilates	<input type="checkbox"/>	Wheelchair sports	<input type="checkbox"/>	Cleaning house	<input type="checkbox"/>
Seated aerobics	<input type="checkbox"/>	Yoga	<input type="checkbox"/>	Hiking	<input type="checkbox"/>	Shopping	<input type="checkbox"/>
Treadmill	<input type="checkbox"/>	Mat exercises	<input type="checkbox"/>	Climbing stairs	<input type="checkbox"/>	Travelling	<input type="checkbox"/>

Other, please explain

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

Yes No

Other, please explain

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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

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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

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

Yes

No

If Yes, please explain

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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?

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.