



NeuroBANK™
ALS Natural History
Case Report Forms

Version 2.0

[2018]

ALS Natural History Study eCRF Package

NeuroBANK Baseline	Biomarker Studies (And associated forms)	Other Forms
ALS Gene Mutations	Sample Collection: DNA Sample Collection	ALS Diagnosis
Demographics	Sample Collection: RNA Sample Collection	ALS History
Diagnosis	Sample Collection: Cerebrospinal Fluid (CSF) Sample	Clinical Data Eligibility
Family History Log	Sample Collection: Serum Sample	12-Lead ECG
Medical History	Sample Collection: Plasma Sample	ALS CBS (Cognitive Behavioral Screen)
Referral Information	Sample Collection: Whole Blood Sample	ALS Caregiver Questionnaire
Weight History	Sample Collection: Sample Collection Questionnaire	ALSFRS-R
Military History	Sample Collection: Post LP Phone Call	ALS-Specific QoL Questionnaire – Revised
Physical Trauma/Electrical Trauma	Safety Labs - Chemistry	Ashworth Spasticity Scale
All-Visits Forms	Safety Labs - Hematology	ATLIS
Assistive Devices Log	Safety Labs - Pregnancy Test	Bulbar Function VAS (Visual Analog Scale)
Fall Log	Safety Labs - Urinalysis	CNS Lability Scale
Feeding Log	Skin Biopsy Procedure	MRC Grading
Hospitalization Log		Neurological Examination
Medications Log		Observed Salivation
Non-Invasive Ventilation Log		Ocular History – Ocular Diseases
Clinical Research Participation Log		Ocular History – Ocular Surgery
Neurological Disease Log		Ocular History – Ocular Drugs
Key Events		Ocular Symptoms
Diaphragm Pacing System Device		Habitual Correction
Permanent Assisted Ventilation (PAV)		Optometric Tests
Tracheostomy		Patient Education
Mortality		Physical Examination
Feeding Tube Placement		Pulmonary Function Tests
Pregnancy History		Timed Reading of Test Paragraph
		Timed Swallowing Solids Test
		Timed Swallowing Water Test
		Visit Summary
		Vital Signs

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NeuroBANK Interface Elements

Radio Button – Only one option may be selected

Check Box – Multiple options may be selected

[FIELD DEFINITIONS] Do not appear in the User Interface

[DATE CONTROL] Requires dates in (MM/DD/YYYY) format and future dates are not allowed. Drop down calendars will be available for entry.

[NUMERIC] Requires numeric characters (U may be permitted based on database rules)

ALS Diagnosis

Date of examination: [DATE CONTROL]

ALS DIAGNOSIS			
Does the patient have:	Yes	No	Not Done
1.Topographical location and pattern of progression of UMN and LMN signs, including signs of spread within a region or to other regions, consistent with ALS?	<input type="radio"/>	<input type="radio"/>	
2.Exclusion by electrophysiological testing of all other processes including conduction block that might explain the underlying signs and symptoms?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.Exclusion by neuroimaging of other disease processes such as myelopathy or radiculopathy that might explain observed clinical and electrophysiological signs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please check yes or no if signs are present.

UMN/LMN									
	Clinical						EMG		
	UMN			LMN			LMN		
	Yes	No	Not Done	Yes	No	Not Done	Denervation	No Denervation	Not Done
Bulbar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LUE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RUE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trunk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LLE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RLE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Revised El Escorial criteria for ALS

- Suspected
- Possible
- Probable Laboratory Supported
- Probable
- Definite

ALS History

Where was diagnosis made Outside Center ALS center

Date of symptom onset: [DATE CONTROL]

Date of diagnosis: [DATE CONTROL]

Generalized*

Bulbar

Speech

Swallowing

Axial

Neck

Trunk

Respiratory

Site of onset:

Limb

Upper

Left

Right

Hand/fingers

Arm

Lower

Left

Right

Ankle/foot/toes

Leg

Other: [TEXT]

**Onset in more than one region. Unable to distinctly identify the specific sites of onset.*

ALS Gene Mutations

Mutation Test Results				
Not Tested	Mutation	Result		Laboratory
<input type="checkbox"/>	ANG	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]
<input type="checkbox"/>	C9ORF72	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]
<input type="checkbox"/>	FUS	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]
<input type="checkbox"/>	Progranulin	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]
<input type="checkbox"/>	SETX	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]
<input type="checkbox"/>	SOD1	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]
<input type="checkbox"/>	TAU	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]
<input type="checkbox"/>	TDP-43	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]
<input type="checkbox"/>	VAPB	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]
<input type="checkbox"/>	VCP	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]
	Other: [TEXT]	<input type="radio"/> positive	<input type="radio"/> negative	[TEXT]

Demographics

Date of Birth: [DATE CONTROL]

Age: [NUMERIC]

Sex: Male Female

The patient identifies himself/herself as being:

Ethnic Category: Hispanic or Latino Not Hispanic or Latino

Racial Categories: White
 Black/African American
 Asian
 Native Hawaiian/Pacific Islander
 American Indian/Alaska Native

Diagnosis

Date of Diagnosis: [DATE CONTROL]

ALS Phenotype

- UMN = LMN
- Upper motor neuron predominant (UMND)
- Lower motor neuron predominant (LMND)
- Progressive bulbar palsy (PBP)
- Primary lateral sclerosis (PLS) (UMN only)
- Progressive muscular atrophy (PMA) (LMN Only)

Clinical Data Source:

- Investigator/submitter
- Primary care physician
- Medical record
- Neurologist (other than study investigator)

Family History Log

A detailed family history was obtained: Yes No

<input type="checkbox"/>	Relative	Heredity	Gender	GUID of selected relative	Please select all mutations for which family member has tested positive
--------------------------	----------	----------	--------	---------------------------	---

Remove Line

Add Line

When adding a line

Family History Log Record

Relative

- Mother
- Father
- Sister
- Brother
- Half-sister
- Half-brother
- Daughter
- Son
- Grandmother
- Grandfather
- Aunt
- Uncle
- Cousin
- Other relative [TEXT]

Heredity Paternal Maternal

Gender Male Female

GUID of Relative: [TEXT]

Please select all medical conditions affecting selected family member

- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis
- Dementia
- Down's Syndrome
- Frontotemporal Dementia
- Huntington's Disease
- Parkinson's Disease
- Psychiatric Disorder [TEXT]
- Arthritis
- Asthma
- Cancer
- Circulation Problems

- Diabetes
- Heart Disease
- High Blood Pressure
- Lung Disease
- Stroke
- Other Disease [TEXT]

Genetic testing performed Yes No

Please select all mutations for which family member has tested positive

- ANG
- C9ORF72
- FUS
- Progranulin
- SETX
- SOD1
- TAU
- TDP-43
- VAPB
- VCP
- Other [TEXT]

Medical History

A detailed medical history was obtained: Yes No

<input type="checkbox"/>	Description	Year of Diagnosis	Still Present
--------------------------	-------------	-------------------	---------------

Remove Line

Add Line

When adding a line

Medical History Record

Please enter any medical history the patient may have from any of the following body systems:

Allergies, Cardiovascular, Dermatologic, Endocrine and Metabolic, Gastrointestinal and Hepatic, HEENT, Hematologic and Lymphatic, Immune and Inflammatory, Musculoskeletal, Neurologic, Psychiatric, Respiratory, Urinary and Reproductive

Description [TEXT]

Year of Diagnosis [NUMERIC]

Still Present Yes No

Referral Information

Referring Diagnosis [DROP-DOWN]

Drop-down menu
Adult spinal muscular atrophy (1)
Amyotrophic Lateral Sclerosis (2)
Amyotrophy in multisystem atrophy (3)
Bulbospinal muscular atrophy (4)
Cervical and lumbosacral polyradiculopathy (5)
Cervical Spondylotic myeloradiculopathy (6)
Chronic inflammatory demyelinating polyneuropathy (7)
Cramp-fasciculation syndrome (8)
Diabetic amyotrophy (9)
Inclusion body myositis (10)
Multifocal motor neuropathy (11)
Myasthenia Gravis (12)
Subacute combined degeneration (13)
Other, specify (99) [TEXT]

Date of referring diagnosis visit [DATE CONTROL]

Referral Source

- Neurologist
- Primary Care Physician
- Self
- Other, specify [TEXT]

How many different doctors have you seen for symptoms now known to be related to ALS, before a diagnosis was made? [NUMERIC]

How many medical appointments have you had for symptoms now known to be related to ALS, before a diagnosis was made? [NUMERIC]

Weight History

Date collected [DATE CONTROL]

Weight units

lb kg

The most the patient has ever weighed [NUMERIC]

Weight loss since diagnosis [NUMERIC]

Weight loss in the two months prior to diagnosis [NUMERIC]

Premorbid (normal) weight [NUMERIC]

Maximum weight in the past **12 months** [NUMERIC]

Maximum weight in the past **6 months** [NUMERIC]

Maximum weight in the **past month** [NUMERIC]

Has the patient been able to maintain his/her weight?

Yes No

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Military History

Status: Collected Not Collected

Reason not collected: [TEXT]

Date of Collection: [DATE CONTROL]

Were you ever a member of the armed forces?

Yes No Don't Know

If Yes, in which branch of service were you employed?

- Army
- Navy
- Marines
- Air Force
- Reserves/National Guard
- Coast Guard
- Other (specify): [TEXT]

Were you ever deployed to a war arena?

Yes No

If Yes, to which war arena were you deployed?

- World War II (1939-1945)
- Greek Civil War (1946-1949)
- Arabic Israeli War (1948-1949)
- Korean War (1950-1953)
- Cuban Revolution (1953-1959)
- Algerian War (1954-1962)
- Vietnam War (1955-1975)
- Soviet war in Afghanistan (1979-1989)
- Iran/Iraq War (1980-1988)
- Persian Gulf War (1990- 1991)
- Croatian War of Independence (1991-1995)
- Bosnian War (1992-1995)
- Kosovo War (1998-1999)
- War in Afghanistan (2001-2014)
- Iraq War (2003-2011)
- War in Somalia (2006-2009)
- Gaza War (2008-2009)
- Other (specify): [TEXT]

Physical Trauma/Electrical Trauma

Status: Collected Not Collected

Reason not collected: [TEXT]

Date of Collection: [DATE CONTROL]

The next questions are about injuries to the head and/or neck that you may have had at anytime in their life. These may have occurred during sporting activities, from falls, violence, car accidents or other accidents. Please include injuries from both childhood and adulthood.

TRAUMA HEAD and NECK INJURIES							
HEAD and NECK INJURIES	Have you ever injured your head or neck during respective activities?	IF YES, How many head or neck injuries have you had?	At what age did this <u>FIRST</u> occur?	Did you lose consciousness from this injury?	IF YES, How long were you unconscious?	Did you go to the emergency room or were you hospitalized for this injury?	From this injury, did you have any of the following (check all that apply)?
Have you ever had an injury to your head or neck? Think about any childhood injuries you remember or were told about.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	[NUMERIC]	[NUMERIC] y/o	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Less than 5 minutes <input type="radio"/> 5-59 minutes <input type="radio"/> 1-24 hours <input type="radio"/> Longer than a day <input type="radio"/> Don't Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="checkbox"/> Skull Fracture <input type="checkbox"/> Seizure <input type="checkbox"/> Memory loss, amnesia <input type="checkbox"/> None of the above <input type="checkbox"/> Don't know
Have you ever injured your head or neck in a car accident or from some other moving vehicle accident (e.g. motorcycle, ATV)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	[NUMERIC]	[NUMERIC] y/o	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Less than 5 minutes <input type="radio"/> 5-59 minutes <input type="radio"/> 1-24 hours <input type="radio"/> Longer than a day <input type="radio"/> Don't Know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="checkbox"/> Skull Fracture <input type="checkbox"/> Seizure <input type="checkbox"/> Memory loss, amnesia <input type="checkbox"/> None of the above <input type="checkbox"/> Don't know

<p>Have you ever injured your head or neck in a fall or from being hit by something (e.g., falling from a bike, horse, or rollerblades, falling on ice, being hit by a rock)? Have you ever injured your head or neck playing sports or on the playground?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	<p>[NUMERIC]</p>	<p>[NUMERIC] y/o</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	<p><input type="radio"/> Less than 5 minutes <input type="radio"/> 5-59 minutes <input type="radio"/> 1-24 hours <input type="radio"/> Longer than a day <input type="radio"/> Don't Know</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	<p><input type="checkbox"/> Skull Fracture <input type="checkbox"/> Seizure <input type="checkbox"/> Memory loss, amnesia <input type="checkbox"/> None of the above <input type="checkbox"/> Don't know</p>
<p>Have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	<p>[NUMERIC]</p>	<p>[NUMERIC] y/o</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	<p><input type="radio"/> Less than 5 minutes <input type="radio"/> 5-59 minutes <input type="radio"/> 1-24 hours <input type="radio"/> Longer than a day <input type="radio"/> Don't Know</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	<p><input type="checkbox"/> Skull Fracture <input type="checkbox"/> Seizure <input type="checkbox"/> Memory loss, amnesia <input type="checkbox"/> None of the above <input type="checkbox"/> Don't know</p>
<p>Have you ever been nearby when an explosion or blast occurred? If you served in the military, think about any combat, or training related incidents?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	<p>[NUMERIC]</p>	<p>[NUMERIC] y/o</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	<p><input type="radio"/> Less than 5 minutes <input type="radio"/> 5-59 minutes <input type="radio"/> 1-24 hours <input type="radio"/> Longer than a day <input type="radio"/> Don't Know</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	<p><input type="checkbox"/> Skull Fracture <input type="checkbox"/> Seizure <input type="checkbox"/> Memory loss, amnesia <input type="checkbox"/> None of the above <input type="checkbox"/> Don't know</p>

The next set of questions relate to electrical shocks.

ELECTRICAL SHOCKS			
ELECTRICAL SHOCKS	Have you ever had this type of shock?	IF YES, How many shocks of this type have you received?	At what age did you FIRST receive a shock/trauma of this type?
Have you ever received a severe electrical shock that resulted in unconsciousness?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	[NUMERIC]	[NUMERIC] y/o
Have you ever received a severe electrical shock that resulted in a burn?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	[NUMERIC]	[NUMERIC] y/o
Have you ever received a severe electrical shock that did not result in unconscious or a burn?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	[NUMERIC]	[NUMERIC] y/o

Assistive Devices Log

<input type="checkbox"/>	Mobility	Orthoses	NIV	Communication Device	Other respiratory devices	Communication Device	NIV Usage	Date recommended	Date first used	Date discontinued
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Remove Line

Add Line

When adding a line

Assistive Device Log Record

Mobility

- Walking unassisted
- Bracing/splints
- Cane
- Walker
- Manual wheelchair
- Power scooter
- Power wheelchair
- Other mobility device [TEXT]

Orthoses

- Inserts of any type
- Supramalleolar orthotic (SMO)
- Ankle-foot orthosis (AFO)
- Knee-ankle-foot orthosis (KAFO)
- Hip-knee-ankle orthosis (HKAFO)
- Stander
- Body jacket/corset/Thoracic-lumbar-sacral orthoses (TLSO)
- Reciprocal gait orthoses (RGO)
- Other orthoses [TEXT]

Non-invasive ventilation

- CPAP
- BIPAP
- BIPAP/AVAPS (Average Volume Assured Pressure Support)
- Trilogy NIV
- Other NIV [TEXT]

Other respiratory devices

- Mechanical In-Exsufflator (Cough-assist machine)
- Diaphragm pacing
- High Frequency Chest Wall Oscillation System (Percussion Vest)
- Nebulizer
- Suction
- Tracheostomy
- Trilogy TIV
- Other TIV [TEXT]

Communication Device

- Call chime
- Eye Gaze
- Poster board
- Speech generator device
- Voice amplifier
- Other Communication Device [TEXT]

Other

- Other [TEXT]

NIV Usage

- Single [NUMERIC] hours/day
- Range [NUMERIC] – [NUMERIC] hours/day

Date of physician recommendation [DATE CONTROL]

Date device FIRST used [DATE CONTROL]

Date device discontinued [DATE CONTROL]

Device brand and/or model [TEXT]

Other comments [TEXT]

Fall Log

<input type="checkbox"/>	Date of last visit	Date of current visit	Fall type	Near Fall count	Fall count	Fall reporting type
--------------------------	--------------------	-----------------------	-----------	-----------------	------------	---------------------

Remove Line

Add Line

When adding a line

Fall Log Record

Date of last visit [DATE CONTROL]

Date of current visit [DATE CONTROL]

During this time period, the subject experienced:

- No events
- Near Fall(s)
- Fall(s)
- Both (falls and near falls)

Number of *Near Fall* events experienced: [NUMERIC]

Number of *Fall* events experienced: [NUMERIC]

Falls were reported Verbally Documented

Feeding Log

Feeding Log							
<input type="checkbox"/>	Type	Other Type	Frequency	Formula	Calories/feeding	Start date	Stop Date

Remove Line

Add Line

When adding a line

Feeding Log Record

Feeding Type

- Bolus G-tube
- Continuous G-tube
- Oral liquid supplement intake
- Other, specify [TEXT]

Feeding frequency [NUMERIC] times/day

Formula name (*generic or trade name*) [TEXT]

Calorie intake per feeding [NUMERIC] Cal/feeding

Feeding schedule start date [DATE CONTROL]

Feeding schedule stop date [DATE CONTROL]

Hospitalization Log

Hospitalization Log				
<input type="checkbox"/>	Reason	Admission Date	Discharge Date	Ventilated

Remove Line

Add Line

When adding a line

Hospitalization Log Record

Reason [TEXT]

Admission date: [DATE CONTROL]

Discharge date [DATE CONTROL]

Was patient ventilated Yes No

Medications Log

Medications													
<input type="checkbox"/>	Medication	Dose	Unit	Unit other specify	Route	Route other specify	Frequency	Frequency other specify	Was this an Investigational Drug	Indication	Start Date	Stop Date	Note

Remove Line

Add Line

When adding a line

Medications Log Record

Medication/Supplement [TEXT]

Dose [TEXT]

Unit

- micrograms (ucg)
- milligrams (mg)
- grams (g)
- tablet (s)
- capsule (s)
- gtt
- milliequivalent (meq)
- international units (IU)
- units (U)
- other (please specify): [TEXT]

Route

- oral
- intravenous
- subcutaneous
- topical
- inhalation
- transdermal
- rectal
- intramuscular
- sublingual
- PEG
- other (please specify): [TEXT]

Frequency

- QD
- BID
- TID
- QID
- QHS
- continuous IV
- PRN
- other (please specify): [TEXT]

Investigational Drug Yes No

Indication [TEXT]

Start Date [DATE CONTROL]

Stop Date [DATE CONTROL]

Note [TEXT]

Non-Invasive Ventilation Log

Non-Invasive Ventilation Log									
<input type="checkbox"/>	Non-Invasive ventilation type	NIV Usage	NIV hours/day	NIV Usage	NIV Range: Low	NIV Range: High	Date recommended	NIV Start Date	NIV Stop Date
<input type="button" value="Remove Line"/>				<input type="button" value="Add Line"/>					

****When adding a line****

Non-Invasive Ventilation Log Record

Type of NIV used

- CPAP
- BIPAP
- BIPAP/AVAPS (Average Volume Assured Pressure Support)
- Trilogy NIV
- Other NIV [TEXT]

NIV Usage

- Single [NUMERIC] hours/day
- Range [NUMERIC] – [NUMERIC] hours/day

Date recommended by physician [DATE CONTROL]

Start Date [DATE CONTROL]

Stop Date [DATE CONTROL]

Device brand and/or model [TEXT]

Comments [TEXT]

Clinical Research Participation Log

Clinical Research Participation Log		
<input type="checkbox"/>	Name of Clinical Study:	Patient ID in Clinical Study

****When adding a line****

Clinical Research Participation Log Record

Name of Clinical Study: [TEXT]

Patient ID in Study: [TEXT]
(if known)

If patient received an investigational drug as part of the trial, please add an entry to the Medication Log.

Neurological Disease Log

Neurological Disease Log				
☐	Diagnosis Date	Diagnosis Category	Disease Name	Other/Type/Specify
Remove Line				Add Line

When adding a line

Neurological Disease Log Record

Diagnosis Date: [DATE CONTROL]

Behavioral Neurology [DROP-DOWN MENU]

DROP-DOWN MENU
Attention Deficit Disorder
Autism
Tourette Syndrome
Other Behavioral Neurology Disorder

Dementia [DROP-DOWN MENU]

DROP-DOWN MENU
Alzheimer's Dementia

FrontoTemporal Dementia (FTD) [DROP-DOWN MENU]

DROP-DOWN MENU
Amnestic
Behavioral Variant
Primary Progressive Aphasia (PPA)
Lewy Body Dementia
Prion Disease (Type)
Other Dementia (Type)

Headache Disorder [DROP-DOWN MENU]

DROP-DOWN MENU
Hemiplegic Migraine

Leukodystrophy [DROP-DOWN MENU]

DROP-DOWN MENU
Adrenoleukodystrophy (ALD)
Canavan
Late Onset Tay-Sachs (LOTS)
Other Leukodystrophy Disease (Type)

Migraine [DROP-DOWN MENU]

DROP-DOWN MENU
Migraine; Complicated,

Migraine; Uncomplicated
Tension Headaches
Other Headache Disorder (Type)

○ **Motor Neuron Diseases** [DROP-DOWN MENU]

DROP-DOWN MENU
Amyotrophic Lateral Sclerosis (ALS)
Distal Spinal Muscular Atrophy (dSMA)
Hereditary Spastic Paraplegia (HSP)
Hirayama Disease
Kennedy's Disease (SBMA)
Post-Polio Syndrome
Spinomuscular Atrophy (SMA)
Primary Lateral Sclerosis
Progressive spinal muscular atrophy
Other Motor Neuron Disease (Type)

○ **Movement Disorders** [DROP-DOWN MENU]

DROP-DOWN MENU
Ataxia Telangiectasia
Cerebral Palsy (CP)
Cortical Basilar Degeneration (CBD)
DYT3 Dystonia
Friedrich's Ataxia
Huntington's Disease (HD)
Multisystem Atrophy (MSA)
Parkinson's Disease (PD)
Progressive Supranuclear Palsy (PSP)
Spinocerebellar Ataxia (Type)
Other Movement Disorder (Type)

○ **Muscle Diseases** [DROP-DOWN MENU]

DROP-DOWN MENU
Muscular Dystrophy (Type)
Myopathy (Type)
Myositis (Type)
Myotonic Disorder (Type)
Periodic Paralysis
Other Muscle Disease (Type)

○ **Nerve/Nerve Root Diseases** [DROP-DOWN MENU]

DROP-DOWN MENU
Brachial Plexopathy
Charcot-Marie-Tooth Disease (CMT)
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
Guillain-Barre Syndrome (GBS)
Lumbosacral Plexopathy
Multifactor Motor Neuropathy (MMN)
Polyneuropathy (Type)

Radiculopathy (Level)
Vasculitic Neuropathy
Other Neuropathy/Radiculopathy (Type)

Neuroinfectious Disorders [DROP-DOWN MENU]

DROP-DOWN MENU
Infectious Encephalopathy (Specify)
Neuro Lyme
Neuro Syphilis
West Nile Virus (Specify Involvement)
Other Neuroinfectious Disease (Type)

Neuroinflammatory Disorders [DROP-DOWN MENU]

DROP-DOWN MENU
Acute Disseminated Encephalomyelitis (ADEM)
Multiple Sclerosis (MS)
Neuromyelitis Optica (NMO)
Other Neuroinflammatory Disorder (Type)

Neuro-oncological Disorders [DROP-DOWN MENU]

DROP-DOWN MENU
Acoustic Neuroma
CNS Lymphoma
Glioblastoma
Meningioma
Other Neuro-oncological Disorder (Type)

Neuro-ophthalmology Disorders [DROP-DOWN MENU]

DROP-DOWN MENU
Ischemic Optic Neuropathy
Norrie Disease
Other Neuro-ophthalmology Disorder (Type)

Neurovascular Disorders [DROP-DOWN MENU]

DROP-DOWN MENU
CNS Vasculitis
Hemorrhagic Stroke
Ischemic Stroke
Subarachnoid Hemorrhage (SAH)
Subdural Hemorrhage (SDH)
Other Neurovascular Disease (Type)

Seizure Disorder [DROP-DOWN MENU]

DROP-DOWN MENU
Benign Rolandic Epilepsy
Juvenile Myoclonic Epilepsy
Temporal Lobe Epilepsy
Other Seizure Disorder (Type)

Other/Type/Specify: [TEXT]

Diaphragm Pacing System Device

Date Recommended: [DATE CONTROL]

Admission Date: [DATE CONTROL]

Date of Placement: [DATE CONTROL]

Discharge Date: [DATE CONTROL]

Permanent Assisted Ventilation (PAV)

Did the patient reach permanent assisted ventilation (PAV):

Yes

No

If Yes, date started: [DATE CONTROL]

Comments: [TEXT]

Tracheostomy

Date Recommended [DATE CONTROL]

Date of Tracheostomy: [DATE CONTROL]

Admission date: [DATE CONTROL]

Discharge date: [DATE CONTROL]

Please specify the reason for tracheostomy:

- Respiratory failure
- Secretion control
- Other (specify): [TEXT]

Feeding Tube Placement

Date recommended [DATE CONTROL]

Date accepted [DATE CONTROL]

Admission date: [DATE CONTROL]

Discharge date: [DATE CONTROL]

Type of feeding tube Nasogastric Gastrostomy

Placement method

- General surgery
- Interventional Radiology
- Microscopic Laparotomy
- Percutaneous Endoscopic Gastrostomy
- Other, specify: [TEXT]

Feeding tube placement was: Prophylactic/elective Emergent

Morbidity/mortality related to feeding tube:

- Aspiration
- Death (*Please complete Mortality form*)
- Excessive Pain
- Hemorrhage
- Local infection
- Nausea/vomiting
- Oxygen desaturation/inadequate ventilation during procedure
- Peritonitis
- Procedure aborted secondary to anatomy
- Other, specify: [TEXT]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Pregnancy History

Date Reported: [DATE CONTROL]

Pregnancy History								
	0	1	2	3	4	5	6	>6
Number of Pregnancies:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Number of Normal Deliveries:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spontaneous Miscarriage:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Clinical Data Eligibility

INCLUSION CRITERIA

Age 18 or older. Yes No

Diagnosis of suspected, possible, probable, probable laboratory supported, or definite ALS by El Escorial Criteria (EEC).

Yes No

Enter initials to attest that the patient has met the eligibility criteria for this project. [TEXT]

After entering initials, form will be locked upon saving

12 Lead ECG

Status Collected Not Collected

Reason not collected [TEXT]

Date Performed [DATE CONTROL]

Interpreter's Initials [TEXT]

12-Lead ECG Measurements							
Heart Rate	PR Interval	QRS Duration	QT Interval	QTc Interval	P-R-T Axes		
					P Axis	R Axis	T Axis
[NUMERIC]	[NUMERIC]	[NUMERIC]	[NUMERIC]	[NUMERIC]	[NUMERIC]	[NUMERIC]	[NUMERIC]

12-Lead ECG			
Normal	Abnormal		Comments
ECG Normal <input type="radio"/>	Clinically Significant <input type="radio"/>	Not Clinically Significant <input type="radio"/>	[TEXT]

If abnormal, check all that apply:		
<input type="checkbox"/> 1 = Sinus bradycardia	<input type="checkbox"/> 8 = Premature atrial complexes	<input type="checkbox"/> 15 = Left axis deviation
<input type="checkbox"/> 2 = Sinus tachycardia	<input type="checkbox"/> 9 = Premature ventricular complexes	<input type="checkbox"/> 16 = Left atrial enlargement
<input type="checkbox"/> 3 = Sick sinus syndrome	<input type="checkbox"/> 10 = Ventricular tachycardia	<input type="checkbox"/> 17 = Left ventricular hypertrophy
<input type="checkbox"/> 4 = Atrial flutter	<input type="checkbox"/> 11 = Ventricular fibrillation	<input type="checkbox"/> 18 = Infarction
<input type="checkbox"/> 5 = Atrial fibrillation	<input type="checkbox"/> 12 = Prolonged PR interval / Heart block	<input type="checkbox"/> 19 = Nonspecific STTWA
<input type="checkbox"/> 6 = Atrial tachycardia	<input type="checkbox"/> 13 = STTWA suggestive of ischemia	<input type="checkbox"/> 99 = Other
<input type="checkbox"/> 7 = Marked sinus pauses	<input type="checkbox"/> 14 = Bundle branch block	[TEXT]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

ALS CBS (Cognitive Behavioral Screen)

Status Collected Not Collected

Reason not collected [TEXT]

Date Performed: [DATE CONTROL]

Evaluator's Initials: [TEXT]

Mark if patient responses were written

Attention

a. **Commands:** *I am, going to say some commands. Please listen carefully and then do what I say. (If patient is unable to indicate with finger, movement can be substituted with eyes, arm or other means).*

1. Point/indicate (with your finger) to the ceiling and then to your left.
2. Touch your shoulder, point to the floor, and then make a fist.

Number of errors 0 1+

b. **Mental Additional/Language:** *I am going to say some phrases. I want you to tell me the number of syllables in each phrase. For example, "the table" has 3 syllables. (Repetition of each phrase is allowed once).*

1. The weather is nice. [NUMERIC] (answer)
(correct response: 5)
 Subject took >20 seconds
2. Tomorrow will be sunny. [NUMERIC] (answer)
(correct response: 7)
 Subject took >20 seconds

c. **Eye Movements: Saccades and Antisaccades**

of correct Saccades out of 8 [DROP-DOWN MENU 0-8: [0], [1], [2], [3], [4], [5], [6], [7], [8]]
/8

of correct Antisaccades out of 8 [DROP-DOWN MENU 0-8: [0], [1], [2], [3], [4], [5], [6], [7], [8]]
/8

[AUTO-CALCULATED] /5 (Subtotal)

Concentration

I am going to say some numbers. After I say them, I want you to say them to me backwards, or in reverse order. For example, if I say 3-6, you would say 6-3. (If written, do not allow pt to write forward span. Discontinue after failure on two consecutive trials).

- | | | |
|-----------------------|-------------------------------|---------------------------------|
| 2-9 (9-2) | <input type="radio"/> Correct | <input type="radio"/> Incorrect |
| 6-4 (4-6) | <input type="radio"/> Correct | <input type="radio"/> Incorrect |
| 3-7-2 (2-7-3) | <input type="radio"/> Correct | <input type="radio"/> Incorrect |
| 5-8-1 (1-8-5) | <input type="radio"/> Correct | <input type="radio"/> Incorrect |
| 7-8-6-4 (4-6-8-7) | <input type="radio"/> Correct | <input type="radio"/> Incorrect |
| 5-4-1-9 (9-1-4-5) | <input type="radio"/> Correct | <input type="radio"/> Incorrect |
| 8-2-5-9-3 (3-9-5-2-8) | <input type="radio"/> Correct | <input type="radio"/> Incorrect |
| 5-7-6-3-9 (9-3-6-7-5) | <input type="radio"/> Correct | <input type="radio"/> Incorrect |

[AUTO-CALCULATED] /5 (Subtotal)

Tracking/Monitoring

- a. **Months:** Please say the months of the year backwards, starting with December.

Dec Nov Oct Sep Aug Jul Jun May Apr Mar Feb Jan

Number of Errors 0 1 2+

- b. **Alphabet:** Please say/write the alphabet for me

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Number of errors 0 1+

- c. **Alternation Task:** I want you to alternate between numbers and letters, starting with 1-A, and then 2-B, 3-C, and so on. Please continue from there, alternating between number-letter, number-letter, in order, without skipping any until I tell you to stop. (Errors: Any mistake in sequencing, i.e., 7-R, or 8-9).

4-D 5-E 6-F 7-G 8-H 9-I 10-J 11-K 12-L 13-M

Number of errors 0 1 2

[AUTO-CALCULATED] /5 (Subtotal)

Initiation and Retrieval

Say (write) as many words as you can starting with the letter F, as quickly as you can, in 1 minute. (Show pt Fluency Rules) You cannot say/write the names of people, places or numbers. Please do not say/write the same word with just a different ending, like truck, trucks. (S words can be substituted for F words). Errors: repetitions, rule violations.

- | | |
|------------|------------|
| 1. [TEXT] | 11. [TEXT] |
| 2. [TEXT] | 12. [TEXT] |
| 3. [TEXT] | 13. [TEXT] |
| 4. [TEXT] | 14. [TEXT] |
| 5. [TEXT] | 15. [TEXT] |
| 6. [TEXT] | 16. [TEXT] |
| 7. [TEXT] | 17. [TEXT] |
| 8. [TEXT] | 18. [TEXT] |
| 9. [TEXT] | 19. [TEXT] |
| 10. [TEXT] | 20. [TEXT] |

Number of correct words	<input type="radio"/> ≤4	<input type="radio"/> <8	<input type="radio"/> 8-12	<input type="radio"/> >12
Number of errors	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	

[AUTO-CALCULATED] /5 (Subtotal)

[AUTO-CALCULATED] /20 (Total)

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

ALS Caregiver Questionnaire

Status Collected Not Collected

Reason not collected: [TEXT]

Was consent obtained from the caregiver completing this questionnaire? Yes No N/A

Caregiver's Initials: [TEXT]

Relation to patient: [DROP-DOWN MENU: Child, Friend, Home aide, In-home nurse, Long-term care/Nursing facility staff, Neighbor, Other Relative, Parent or legal guardian, Roommate or housemate, Sibling, Spouse or partner]

Date performed: [DATE CONTROL]

These questions pertain to possible changes that you have noticed since the onset of ALS symptoms. As best you can, consider changes unrelated to physical weakness. For example, question #1 asks about interest in activities. If the person can no longer play tennis but still seems interested in it (i.e. talks about it, watches it on TV), then you would select *No Change*

If the person has always had the trait in question, respond *No Change*, since there has been no change

Compared to before ALS, does he/she:	No Change	Small Change	Medium Change	Large Change
1. Have less interest in topics/events that used to be important to them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Show little emotion, or seem less responsive emotionally?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Seem more agreeable or pleasant than in the past with fewer worries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Fail to think things through before acting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Seem more withdrawn from others but not sad?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Get confused or distracted more easily?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Have less ability to deal with frustration or stress?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Seem less concerned about the feelings or concerns of others than before?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Get angry or irritable more easily than before?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Seem more sarcastic or childlike than before?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Eat more or have a new preference for particular foods (i.e. sweets)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Have more trouble changing opinions or adapting to new situations?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Show less judgment or more problems making good decisions (i.e. regarding safety, finances, etc)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Have less awareness of obvious problems or changes, or deny them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Have new problems with language, such as saying the wrong word more often, making up new words, or declines in spelling ability?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Total Score: [AUTO-CALCULATED] /45

The following questions relate to current symptoms, not changes over time.

Do you think your loved one:

- | | | |
|--|---------------------------|--------------------------|
| Seems depressed on most days? | <input type="radio"/> Yes | <input type="radio"/> No |
| Seems anxious on most days? | <input type="radio"/> Yes | <input type="radio"/> No |
| Seems extremely fatigued on most days? | <input type="radio"/> Yes | <input type="radio"/> No |
| Suffers from unexpected crying or laughing spells? | <input type="radio"/> Yes | <input type="radio"/> No |

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

ALSFRS-R

Status Collected Not Collected

Reason not collected [TEXT]

Date Performed: [DATE CONTROL]

Mode of administration:

- In Person
- Telephone
- Self-administered
- Other [TEXT]

Responded by: Patient Patient via Caregiver

Evaluators Initials: [TEXT]

QUESTIONS:

1. Speech

- 4 = Normal speech processes
- 3 = Detectable speech disturbances
- 2 = Intelligible with repeating
- 1 = Speech combined with nonvocal communication
- 0 = Loss of useful speech

2. Salivation

- 4 = Normal
- 3 = Slight but definite excess of saliva in mouth; may have nighttime drooling
- 2 = Moderately excessive saliva; may have minimal drooling
- 1 = Marked excess of saliva with some drooling
- 0 = Marked drooling; requires constant tissue or handkerchief

3. Swallowing

- 4 = Normal eating habits
- 3 = Early eating problems – occasional choking
- 2 = Dietary consistency changes
- 1 = Needs supplemental tube feeding
- 0 = NPO (exclusively parenteral or enteral feeding)

4. Handwriting

- 4 = Normal
- 3 = Slow or sloppy; all words are legible
- 2 = Not all words are legible
- 1 = Able to grip pen but unable to write
- 0 = Unable to grip pen

Subject has a gastrostomy:

- 1=Yes
- 2=No

5a. Cutting Food and Handling Utensils (patients without gastrostomy)

- 4 = Normal
- 3 = Somewhat slow and clumsy, but no help needed
- 2 = Can cut most foods, although clumsy and slow; some help needed
- 1 = Food must be cut by someone, but can still feed slowly
- 0 = Needs to be fed

5b. Cutting Food and Handling Utensils (alternate scale for patients with gastrostomy)

- 4 = Normal
- 3 = Clumsy but able to perform all manipulations independently
- 2 = Some help needed with closures and fasteners
- 1 = Provides minimal assistance to caregivers
- 0 = Unable to perform any aspect of task

6. Dressing and Hygiene

- 4 = Normal function
- 3 = Independent and complete self-care with effort or decreased efficiency
- 2 = Intermittent assistance or substitute methods
- 1 = Needs attendant for self-care
- 0 = Total dependence

7. Turning in Bed and Adjusting Bed Clothes

- 4 = Normal
- 3 = Somewhat slow and clumsy, but no help needed
- 2 = Can turn alone or adjust sheets, but with great difficulty
- 1 = Can initiate, but not turn or adjust sheets alone
- 0 = Helpless

8. Walking

- 4 = Normal
- 3 = Early ambulation difficulties
- 2 = Walks with assistance
- 1 = Nonambulatory functional movement only
- 0 = No purposeful leg movement

9. Climbing Stairs

- 4 = Normal
- 3 = Slow
- 2 = Mild unsteadiness or fatigue
- 1 = Needs assistance
- 0 = Cannot do

R-1 Dyspnea

- 4 = None
- 3 = Occurs when walking
- 2 = Occurs with one or more of the following: eating, bathing, dressing
- 1 = Occurs at rest, difficulty breathing when either sitting or lying
- 0 = Significant difficulty, considering using mechanical respiratory support

R-2 Orthopnea

- 4 = None
- 3 = Some difficulty sleeping at night due to shortness of breath, does not routinely use more than two pillows
- 2 = Needs extra pillow in order to sleep (more than two)
- 1 = Can only sleep sitting up
- 0 = Unable to sleep without mechanical assistance

R-3 Respiratory Insufficiency

- 4 = None
- 3 = Intermittent use of NIPPV
- 2 = Continuous use of NIPPV during the night
- 1 = Continuous use of NIPPV during the night and day
- 0 = Invasive mechanical ventilation by intubation or tracheostomy

Total: [AUTO-CALCULATED]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

ALS-Specific QoL Questionnaire – Revised

Status: Collected Not Collected

Reason not collected [TEXT]

Date performed: [DATE CONTROL]

Mode of administration:

- Telephone (Subject)
- Self-Report Pencil/Paper Interview
- Telephone (Subject via caregiver)
- Document completed by site staff at direction of subject

Evaluator’s Initials [TEXT]

Please assess your overall quality of life over the past week (7 days):

	0	1	2	3	4	5	6	7	8	9	10
	Very bad										Excellent
Considering all parts of my life: physical, emotional, social, spiritual, and financial over the past week, the quality of my life has been.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

ALS-Specific QoL Questionnaire - Revised	
	Name
Physical Symptoms Q 1-9	
Emotional Experience Q 10 - 21	
Emotional Experience Q 22 - 33	
Emotional Experience Q 34 - 38	
Social Contact Q 39 - 44	
Physical Intimacy Q 45 - 50	

ALS-Specific QoL Questionnaire-Physical Symptoms Q 1-9

Please rate the following symptoms and experiences according to how much of a problem each one has been for you. Please respond about how you have felt or what you have experienced over the past week using the scale provided.

ALS-Specific Quality of Life Questionnaire											
	0 No Problem	1	2	3	4	5	6	7	8	9	10 Tremendous Problem
1. Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Excessive Saliva	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Mucous in My Throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Speaking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. My Strength and Ability to Move	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Bowel and Bladder (Constipation, Diarrhea, Poor Control)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ALS-Specific QoL Questionnaire-Emotional Experience Q 10-21

Please rate the following statements according to how much you have felt or experienced what is described. Please respond about how you have felt or what you have experienced over the past week.

ALS-Specific Quality of Life Questionnaire											
	0 Strongly Disagree	1	2	3	4	5	6	7	8	9	10 Strongly Agree
10. I have felt physically terrible.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. My life has been purposeful and meaningful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I have been coping well with my illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. I believe I have control over my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. When I have thought about my life, I thought that my life to this point has been worthwhile.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. The world has been caring and responsive to my needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I have felt supported.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. ALS has interfered with important things in my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. The past week has been a gift.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I have felt good about myself as a person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. When I have thought about my whole life, I thought that I have achieved my life's goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Whatever the future holds, I know that things will be ok.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ALS-Specific QoL Questionnaire-Emotional Experience Q 22-33

Please rate the following statements according to how much you have felt or experienced what is described. Please respond about how you have felt or what you have experienced over the past week.

ALS-Specific Quality of Life Questionnaire											
	0 Not at All	1	2	3	4	5	6	7	8	9	10 Very Much
22. I have been depressed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. My religion has been a source of strength or comfort to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Communication has been a problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

25. When I have thought of the future, I have been afraid.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Relationships with those closest to me have been satisfying.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. I have been interested in other people or things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. I have been nervous or worried.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. I consider myself to have been religious or spiritual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. I enjoyed spending time with other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. I have felt helpless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. I have felt hopeless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. I have enjoyed the beauty of my surroundings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ALS-Specific QoL Questionnaire-Emotional Experience Q 34-38

Please rate the following statements according to how much you have felt or experienced what is described. Please respond about how you have felt or what you have experienced over the past week.

ALS-Specific Quality of Life Questionnaire											
	0 Never	1	2	3	4	5	6	7	8	9	10 Very Often
34. I have felt sad.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. I have prayed to God.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. I have laughed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. I was excited about or looked forward to something.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. I have engaged in religious practices in my home or in my community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ALS-Specific QoL Questionnaire-Social Contact Q 39-44

The following statements are about social contact (for example, visits from family and friends). Please think about your experiences with or how you have felt about social contact in the past week, and use the scales provided below to respond.

ALS-Specific Quality of Life Questionnaire											
	0 Strongly Disagree	1	2	3	4	5	6	7	8	9	10 Strongly Agree
39. My desire for social contact has been strong.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0 Never	1	2	3	4	5	6	7	8	9	10 Very Often
40. Family and friends have visited me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0 Not at All	1	2	3	4	5	6	7	8	9	10 Very Much
41. Visits from family and friends have been satisfying. (if you have not had any visits, please leave the response section blank).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following statements are about emotional intimacy (for example, sharing deep, private thoughts; feeling connected). Please think about your experiences with or how you have felt about emotional intimacy in the past week, and use the scales provided below to respond.

ALS-Specific Quality of Life Questionnaire											
	0 Strongly Disagree	1	2	3	4	5	6	7	8	9	10 Strongly Agree
42. My desire for emotional intimacy has been strong.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0 Never	1	2	3	4	5	6	7	8	9	10 Very Often
43. I have shared emotional intimacy with other.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0 Not at All	1	2	3	4	5	6	7	8	9	10 Very Much
44. Emotional intimacy with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

has been satisfying. (If you have not shared emotional intimacy, please leave the response section blank).											
--	--	--	--	--	--	--	--	--	--	--	--

ALS-Specific QoL Questionnaire-Physical Intimacy Q 45-50

The following statements are about physical intimacy (for example, touching, hugging, kissing). Please think about your experiences with or how you have felt about physical intimacy in the past week, and use the scales provided below to respond.

ALS-Specific Quality of Life Questionnaire											
	0 Strongly Disagree	1	2	3	4	5	6	7	8	9	10 Strongly Agree
45. My desire for physical intimacy has been strong.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0 Never	1	2	3	4	5	6	7	8	9	10 Very Often
46. I have shared physical intimacy with others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0 Not at All	1	2	3	4	5	6	7	8	9	10 Very Much
47. Physical intimacy with others has been satisfying. (If you have not shared physical intimacy, please leave the response section blank).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following statements are about sexual intercourse. Please think about your experiences with or how you have felt about sexual intercourse in the past week, and use the scales provided below to respond.

ALS-Specific Quality of Life Questionnaire											
	0 Strongly Disagree	1	2	3	4	5	6	7	8	9	10 Strongly Agree
48. My desire for sexual intercourse has been strong.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	0 Never	1	2	3	4	5	6	7	8	9	10 Very Often
49. I have shared sexual intercourse with others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0 Not at All	1	2	3	4	5	6	7	8	9	10 Very Much
50. My sexual relationship has been satisfying. (If you have not had sexual intercourse, please leave the response section blank).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Ashworth Spasticity Scale

Status Collected Not Collected

Reason not collected [TEXT]

Date performed: [DATE CONTROL]

Evaluator's initials: [TEXT]

Key:

1. No increase in muscle tone.
2. Slight increase in tone giving a 'catch' when affected part is moved in flexion or extension
3. More marked increase in tone, but affected part is easily flexed.
4. Considerable increase in tone; passive movement difficult.
5. Affected part is rigid in flexion or extension
6. Not tested
7. Not tested (subject unable to perform task)

Ashworth Spasticity Scale							
<u>Limb</u>	<u>Score</u>						
	1	2	3	4	5	6	7
Right Arm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Left Arm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Right Leg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Left Leg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

ATLIS

Status: Collected Not Collected

Reason not collected [TEXT]

Evaluator’s Initials: [TEXT]

Date Performed: [DATE CONTROL]

ATLIS MUSCLE TESTING		
Muscle Group	Best Value (pounds)	If Not Tested, please explain
LEFT GRIP	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
RIGHT GRIP	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
LEFT ELBOW FLEXION	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
RIGHT ELBOW FLEXION	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
LEFT ELBOW EXTENSION	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
RIGHT ELBOW EXTENSION	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
LEFT ANKLE DORSIFLEXION	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
RIGHT ANKLE DORSIFLEXION	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
LEFT KNEE EXTENSION	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
RIGHT KNEE EXTENSION	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
LEFT KNEE FLEXION	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]
RIGHT KNEE FLEXION	[NUMERIC]	<input type="radio"/> Subject unable to perform task due to weakness <input type="radio"/> Other (Specify): [TEXT]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Bulbar Function VAS (Visual Analog Scale)

Status: Collected Not Collected

Reason not collected: [TEXT]

Date performed: [DATE CONTROL]

Evaluator's Initials: [TEXT]

Function	1	2	3	4	5	6	7	8	9	10
Speech	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swallowing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sialorrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

CNS Liability Scale

Status: Collected Not Collected

Reason not collected: [TEXT]

Date performed: [DATE CONTROL]

Form completed by: Patient Person other than patient

Evaluator's Initials: [TEXT]

Please select the number that describes the degree to which each item has applied to you DURING THE PAST WEEK					
	Does not apply	Rarely Applies	Occasionally Applies	Frequently Applies	Applies Most of the Time
	1	2	3	4	5
1. There are times when I feel fine 1 minute, and then I'll become tearful the next over something small or for no reason at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Others have told me that I seem to become amused very easily or that I seem to become amused about things that aren't funny.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I find myself crying very easily.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I find that even when I try to control my laughter, I am often unable to do so.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. There are times when I won't be thinking of anything happy or funny at all, but then I'll suddenly be overcome by funny or happy thoughts.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I find that even when I try to control my crying, I am often unable to do so.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I find that I am easily overcome by laughter.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TOTAL: [AUTO-CALCULATED]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

DNA Sample Collection

Status: Collected Not Collected

Reason not collected [TEXT]

Date DNA Collected [DATE CONTROL]

Collector's Initials [TEXT]

Collection number [NUMERIC]

Number of DNA Tubes Collected [NUMERIC]

RNA Sample Collection

Status: Collected Not Collected

Reason not collected [TEXT]

Date RNA Collected [DATE CONTROL]

Collector's Initials [TEXT]

Collection number [NUMERIC]

Number of RNA Tubes Collected [NUMERIC]

MRC Grading

Status: Collected Not Collected

Reason not collected [TEXT]

Date administered [DATE CONTROL]

Evaluator's Initials [TEXT]

Score (Left)											
Test Area	0	0+ / 1-	1	1+ / 2-	2	2+ / 3-	3	3+ / 4-	4	4+ / 5-	5
Shoulder Abduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shoulder Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shoulder Extension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shoulder Internal Rotation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elbow Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elbow Extension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wrist Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wrist Extension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Finger Abduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thumb Abduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip Extension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Hip Abduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip Adduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knee Extension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knee Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ankle Dorsal Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ankle Plantar Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Score (Right)											
Test Area	0	0+ / 1-	1	1+ / 2-	2	2+ / 3-	3	3+ / 4-	4	4+ / 5-	5
Shoulder Abduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shoulder Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shoulder Extension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shoulder Internal Rotation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elbow Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elbow Extension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wrist Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wrist Extension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Finger Abduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thumb Abduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip Extension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip Abduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip Adduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knee Extension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knee Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ankle Dorsal Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ankle Plantar Flexion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Neurological Examination

Status: Collected Not Collected

Reason not collected [TEXT]

Date of Exam: [DATE CONTROL]

Examiner's Initials [TEXT]

GENERAL	Normal	Abnormal	Not Done	Comments
Level of Consciousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Level of Appearance/Facial/Motor Expression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Mental Status	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
CRANIAL NERVES	Normal	Abnormal	Not Done	Comments
Vision (II)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Eye Movements (III, IV, VI)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Jaw movement and facial sensation (V)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Facial motion (VII)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Hearing (VIII)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Swallowing, pharynx, larynx (IX, X)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
SCM, trapezius (XI)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Tongue (XII)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]

Plantar	Down	Up	Mute	Not Done	Comments
Left foot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Right foot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]

MOTOR SYSTEM	Normal	Abnormal	Not Done	Comments
General Movement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Muscle Bulk/Mass	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Muscle Strength:				
Trunk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Left Upper Extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Right Upper Extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Left Lower Extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Right Lower Extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Muscle Tone:				
Left Upper Extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Right Upper Extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Left Lower Extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Right Lower Extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
COORDINATION / CEREBELLAR FUNCTION	Normal	Abnormal	Not Done	Comments
Gait	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Nystagmus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Finger-Nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]

SENSATION	Normal	Abnormal	Not Done	Comments
Upper Extremities				
Pain/Temperature	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Light Touch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Position	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Vibration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]

Lower Extremities				
Pain / Temperature	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Light Touch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Position	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
Vibration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]

Reflexes													
Not Done	Left	0	1+	2+	3+	4+	Not Done	Right	0	1+	2+	3+	4+
<input type="checkbox"/>	Pectoral	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Pectoral	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/>	Biceps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Biceps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/>	Brachioradials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Brachioradials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/>	Triceps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Triceps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/>	Knee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Knee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/>	Ankle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Ankle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/>	Plantar	[DROP-DOWN MENU]					<input type="checkbox"/>	Plantar	[DROP-DOWN MENU]				
<input type="checkbox"/>	Abdominals	[DROP-DOWN MENU]					<input type="checkbox"/>	Abdominals	[DROP-DOWN MENU]				
<input type="checkbox"/>	Hoffman sign	[DROP-DOWN MENU]					<input type="checkbox"/>	Hoffman sign	[DROP-DOWN MENU]				

Jaw reflexes Absent Normal Brisk

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Observed Salivation

Status: Collected Not Collected

Reason not collected [TEXT]

Date performed: [DATE CONTROL]

Evaluator's Initials: [TEXT]

OBSERVED SALIVATION		
Symptom	Finding	Comments
Resting Drooling	<input type="radio"/> Present <input type="radio"/> Absent	[TEXT]
Resting Dabbing	<input type="radio"/> Yes <input type="radio"/> No	[TEXT]
Stimulated Drooling	<input type="radio"/> Present <input type="radio"/> Absent	[TEXT]
Stimulated Dabbing	<input type="radio"/> Yes <input type="radio"/> No	[TEXT]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Ocular History: Ocular Diseases

Does the patient have active ocular disease, or a history of ocular disease?

- Yes No

If yes, please specify which of the following:

Check all that apply	Ocular Diseases	Which Eye? (Right Eye: RE; Left Eye: LE)	LE Diagnosis Date	RE Diagnosis Date	Other Details
<input type="checkbox"/>	Glaucoma	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Age-related macular degeneration	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Diabetic retinopathy	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Macular degeneration	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Retinal detachment	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Keratoconus	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Cataract	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Strabismus	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Amplyopia	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Other (Type): [TEXT]	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]

Ocular History: Ocular Surgery

Has the patient had ocular surgery?

- Yes No

If yes, please specify which of the following:

Check all that apply	Ocular Surgery	Which Eye? (Right Eye: RE; Left Eye: LE)	RE Surgery Date	LE Surgery Date	Other Details
<input type="checkbox"/>	Refractive Surgery	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Cataract Surgery	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Eyelid Surgery	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Glaucoma Surgery	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Vitreoretinal Surgery	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Strabismus Surgery	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Tear apparatus Surgery	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Eye removal (prosthetic eye)	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]
<input type="checkbox"/>	Other (Type): [TEXT]	<input type="radio"/> RE <input type="radio"/> LE <input type="radio"/> Both	[DATE CONTROL]	[DATE CONTROL]	[TEXT]

Ocular History: Ocular Drugs

Does the patient take ocular drugs?

Yes No

If yes, please specify: [TEXT]

Habitual Correction

Does the patient wear glasses?

- Yes No

If yes, please select the habitual ophthalmic correction:

- Distance
 Near
 Both

Near [NUMERIC] (cm)

Ophthalmic Lenses Type:

- Single vision lenses
 Progressive addition lenses
 Bifocal lenses
 Occupational lenses
 Preassembling reading glasses

Distance	Sph (D)	Cyl (D)	Axis (o)	Distance Visual Acuity (LogMAR)	Binocular Distance Visual Acuity(LogMAR)
Right Eye Distance Vision Lenses	[DROP-DOWN MENU: +, -] [NUMERIC]	[DROP-DOWN MENU: +, -] [NUMERIC]	[NUMERIC]	<input type="radio"/> VA > 1.00 <input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]	<input type="radio"/> VA > 1.00 <input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]
Left Eye Distance Vision Lenses	[DROP-DOWN MENU: +, -] [NUMERIC]	[DROP-DOWN MENU: +, -] [NUMERIC]	[NUMERIC]	<input type="radio"/> VA > 1.00 <input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]	

Near	Sph (D)	Cyl (D)	Axis (o)	Binocular Near Visual Acuity (LogMAR)
Right Eye Near Vision Lenses	[DROP-DOWN MENU: +, -] [NUMERIC]	[DROP-DOWN MENU: +, -] [NUMERIC]	[NUMERIC]	<input type="radio"/> VA > 1.00 <input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]
Left Eye Near Vision Lenses	[DROP-DOWN MENU: +, -] [NUMERIC]	[DROP-DOWN MENU: +, -] [NUMERIC]	[NUMERIC]	

Does the patient wear contact lenses?

- Yes No

If yes, please select the habitual contact lenses:

- Monofocal contact lenses
 Multifocal contact lenses

Select the type of contact lenses:

- RGP (Rigid Gas Permeable)
 Soft lenses
 Other: [TEXT]

Distance Contact Lenses	Sph (D)	Cyl (D)	Axis (o)	Distance Visual Acuity (LogMAR)	Binocular Distance Visual Acuity (LogMAR)
Right Eye Distance Vision Contact Lenses	[DROP-DOWN MENU: +, -] [NUMERIC]	[DROP-DOWN MENU: +, -] [NUMERIC]	[NUMERIC]	<input type="radio"/> VA > 1.00 <input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]	<input type="radio"/> VA > 1.00 <input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]
Left Eye Distance Vision Contact Lenses	[DROP-DOWN MENU: +, -] [NUMERIC]	[DROP-DOWN MENU: +, -] [NUMERIC]	[NUMERIC]	<input type="radio"/> VA > 1.00 <input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]	

Multifocal Contact Lenses	Addition	Binocular Near Visual Acuity (LogMAR)
Right Eye	<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High	<input type="radio"/> VA > 1.00
Left Eye	<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High	<input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]

Ocular Symptoms

Does the patient have ocular symptoms?

Yes No

If yes, please specify which of the following:

Check all that apply	Ocular Symptom	Duration of Symptom Onset	Duration Unit	Please specify if it is related to a specific activity, i.e. watch television, using eye-tracking assistive device, etc.
<input type="checkbox"/>	Distance Blurred Vision	[NUMERIC]	[DROP-DOWN MENU: Days] [DROP-DOWN MENU: Weeks] [DROP-DOWN MENU: Months] [DROP-DOWN MENU: Years]	[TEXT]
<input type="checkbox"/>	Near Blurred Vision	[NUMERIC]	[DROP-DOWN MENU: Days] [DROP-DOWN MENU: Weeks] [DROP-DOWN MENU: Months] [DROP-DOWN MENU: Years]	[TEXT]
<input type="checkbox"/>	Diplopia	[NUMERIC]	[DROP-DOWN MENU: Days] [DROP-DOWN MENU: Weeks] [DROP-DOWN MENU: Months] [DROP-DOWN MENU: Years]	[TEXT]
<input type="checkbox"/>	Eyestrain	[NUMERIC]	[DROP-DOWN MENU: Days] [DROP-DOWN MENU: Weeks] [DROP-DOWN MENU: Months] [DROP-DOWN MENU: Years]	[TEXT]
<input type="checkbox"/>	Burning eye	[NUMERIC]	[DROP-DOWN MENU: Days] [DROP-DOWN MENU: Weeks] [DROP-DOWN MENU: Months] [DROP-DOWN MENU: Years]	[TEXT]
<input type="checkbox"/>	Epiphora	[NUMERIC]	[DROP-DOWN MENU: Days] [DROP-DOWN MENU: Weeks] [DROP-DOWN MENU: Months] [DROP-DOWN MENU: Years]	[TEXT]
<input type="checkbox"/>	Dry eye	[NUMERIC]	[DROP-DOWN MENU: Days] [DROP-DOWN MENU: Weeks] [DROP-DOWN MENU: Months] [DROP-DOWN MENU: Years]	[TEXT]
<input type="checkbox"/>	Photophobia	[NUMERIC]	[DROP-DOWN MENU: Days] [DROP-DOWN MENU: Weeks] [DROP-DOWN MENU: Months] [DROP-DOWN MENU: Years]	[TEXT]
<input type="checkbox"/>	Other (Type): [TEXT]	[NUMERIC]	[DROP-DOWN MENU: Days] [DROP-DOWN MENU: Weeks] [DROP-DOWN MENU: Months] [DROP-DOWN MENU: Years]	[TEXT]

Optometric Tests

Not Done	Test	Vision Type
<input type="checkbox"/>	Distance Fusion	[DROP-DOWN MENU: Fusion] [DROP-DOWN MENU: Diplopia] [DROP-DOWN MENU: Suppression – RE] [DROP-DOWN MENU: Suppression – LE] [DROP-DOWN MENU: Suppression – Both]
<input type="checkbox"/>	Near Fusion	[DROP-DOWN MENU: Fusion] [DROP-DOWN MENU: Diplopia] [DROP-DOWN MENU: Suppression – RE] [DROP-DOWN MENU: Suppression – LE] [DROP-DOWN MENU: Suppression – Both]

Not Done	Test	Measurement (arcsec)
<input type="checkbox"/>	Habitual Stereopsis	[NUMERIC]
<input type="checkbox"/>	Stereopsis With new Correction	[NUMERIC]

Not Done	Test	Measurement (mm)
<input type="checkbox"/>	Right Eye (RE) Pupil	[NUMERIC]
<input type="checkbox"/>	Left Eye (LE) Pupil	[NUMERIC]
<input type="checkbox"/>	Interpupillary Distance	[NUMERIC]

Not Done	Test	Sph (D)	Cyl (D)	Axis (o)	Distance Visual Acuity with new correction (LogMAR)	Binocular Distance Visual Acuity with new correction (LogMAR)
<input type="checkbox"/>	Binocular Refraction (RE)	[DROP-DOWN MENU: +, -] [NUMERIC]	[DROP-DOWN MENU: +, -] [NUMERIC]	[NUMERIC]	<input type="radio"/> VA > 1.00 <input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]	<input type="radio"/> VA > 1.00 <input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]
<input type="checkbox"/>	Binocular Refraction (LE)	[DROP-DOWN] [NUMERIC]	[DROP-DOWN] [NUMERIC]	[NUMERIC]	<input type="radio"/> VA > 1.00	

		MENU: +, -] [NUMERIC]	MENU: +, -] [NUMERIC]		<input type="radio"/> [DROP-DOWN MENU: +, -] [NUMERIC]	
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Not Done	Test	Measurements
<input type="checkbox"/>	Addition Lenses	[NUMERIC] (D)
<input type="checkbox"/>	Near Working Distance	[NUMERIC] (cm)
<input type="checkbox"/>	Binocular Near Visual Acuity With New Correction	[NUMERIC] (LogMAR)

Not Done	Refractive Error	Refractive Error Type
<input type="checkbox"/>	RE	[DROP-DOWN MENU: Emmetropia] [DROP-DOWN MENU: Myopia] [DROP-DOWN MENU: Hyperopia] [DROP-DOWN MENU: Myopic Astigmatism] [DROP-DOWN MENU: Hyperopic Astigmatism] [DROP-DOWN MENU: Mixed Astigmatism]
<input type="checkbox"/>	LE	[DROP-DOWN MENU: Emmetropia] [DROP-DOWN MENU: Myopia] [DROP-DOWN MENU: Hyperopia] [DROP-DOWN MENU: Myopic Astigmatism] [DROP-DOWN MENU: Hyperopic Astigmatism] [DROP-DOWN MENU: Mixed Astigmatism]

Not Done	Test	SAFE	If Not SAFE, please specify:
<input type="checkbox"/>	Broad H Test	<input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Referred Diplopia <input type="checkbox"/> Delayed Movements <input type="checkbox"/> Imprecise Movements <input type="checkbox"/> Other: [TEXT]

Not Done	Test	NPC Measurement
<input type="checkbox"/>	Near Point of Convergence (NPC), Break Point	<input type="radio"/> To nose <input type="radio"/> >15 cm <input type="radio"/> [NUMERIC] (cm)

Cover Test - Distance								
Not Done	Ocular Misalignment	Direction	Horizontal Deviation	Horizontal Laterality	Vertical Deviation	Vertical Laterality	Frequency	Other Details
<input type="checkbox"/>	Tropia	<input type="radio"/> Horizontal deviation <input type="radio"/> Vertical deviation	<input type="radio"/> NMD* <input type="radio"/> Exotropia <input type="radio"/> Esotropia	<input type="radio"/> Right Eye <input type="radio"/> Left Eye <input type="radio"/> Alternating	<input type="radio"/> NMD* <input type="radio"/> Hypotropia <input type="radio"/> Hypertropia	<input type="radio"/> Right Eye <input type="radio"/> Left Eye <input type="radio"/> Alternating	<input type="radio"/> Intermittent <input type="radio"/> Constant	[TEXT]
<input type="checkbox"/>	Phoria	<input type="radio"/> Horizontal deviation <input type="radio"/> Vertical deviation	<input type="radio"/> NMD* <input type="radio"/> Exophoria <input type="radio"/> Esophoria		<input type="radio"/> NMD* <input type="radio"/> Hyperphoria RE <input type="radio"/> Hyperphoria LE			[TEXT]
Cover Test - Near								
Not Done	Ocular Misalignment	Direction	Horizontal Deviation	Horizontal Laterality	Vertical Deviation	Vertical Laterality	Frequency	Other Details
<input type="checkbox"/>	Tropia	<input type="radio"/> Horizontal deviation <input type="radio"/> Vertical deviation	<input type="radio"/> NMD* <input type="radio"/> Exotropia <input type="radio"/> Esotropia	<input type="radio"/> Right Eye <input type="radio"/> Left Eye <input type="radio"/> Alternating	<input type="radio"/> NMD* <input type="radio"/> Hypotropia <input type="radio"/> Hypertropia	<input type="radio"/> Right Eye <input type="radio"/> Left Eye <input type="radio"/> Alternating	<input type="radio"/> Intermittent <input type="radio"/> Constant	[TEXT]
<input type="checkbox"/>	Phoria	<input type="radio"/> Horizontal deviation <input type="radio"/> Vertical deviation	<input type="radio"/> NMD* <input type="radio"/> Exophoria <input type="radio"/> Esophoria		<input type="radio"/> NMD* <input type="radio"/> Hyperphoria RE <input type="radio"/> Hyperphoria LE			[TEXT]

* NMD: No Movement Detected

Not Done	Northeastern State University College of Optometry (NSUCO)			
	Test	Ability	Accuracy	Head Movement
<input type="checkbox"/>	Oculomotor Test Saccades	[DROP-DOWN MENU: 1] [DROP-DOWN MENU: 2] [DROP-DOWN MENU: 3] [DROP-DOWN MENU: 4] [DROP-DOWN MENU: 5]	[DROP-DOWN MENU: 1] [DROP-DOWN MENU: 2] [DROP-DOWN MENU: 3] [DROP-DOWN MENU: 4] [DROP-DOWN MENU: 5]	[DROP-DOWN MENU: 1] [DROP-DOWN MENU: 2] [DROP-DOWN MENU: 3] [DROP-DOWN MENU: 4] [DROP-DOWN MENU: 5] [DROP-DOWN MENU: Not Evaluable: 95]
<input type="checkbox"/>	Oculomotor Test Pursuits	[DROP-DOWN MENU: 1] [DROP-DOWN MENU: 2] [DROP-DOWN MENU: 3] [DROP-DOWN MENU: 4] [DROP-DOWN MENU: 5]	[DROP-DOWN MENU: 1] [DROP-DOWN MENU: 2] [DROP-DOWN MENU: 3] [DROP-DOWN MENU: 4] [DROP-DOWN MENU: 5]	[DROP-DOWN MENU: 1] [DROP-DOWN MENU: 2] [DROP-DOWN MENU: 3] [DROP-DOWN MENU: 4] [DROP-DOWN MENU: 5] [DROP-DOWN MENU: Not Evaluable: 95]

Patient Education

Status Collected Not Collected

Reason not collected [TEXT]

Date Performed: [DATE CONTROL]

Evaluator's Initials [TEXT]

Indicate all patient education items discussed during this visit	
	Comments
<input type="checkbox"/> Advanced directives	[TEXT]
<input type="checkbox"/> Caregiver support	[TEXT]
<input type="checkbox"/> Emergency plan	[TEXT]
<input type="checkbox"/> Enteral education including PEG or RIG	[TEXT]
<input type="checkbox"/> Heimlich maneuver	[TEXT]
<input type="checkbox"/> Home safety	[TEXT]
<input type="checkbox"/> Hospice	[TEXT]
<input type="checkbox"/> Insurance/Social Security benefits	[TEXT]
<input type="checkbox"/> Living will	[TEXT]
<input type="checkbox"/> Mechanical ventilation	[TEXT]
<input type="checkbox"/> Medical POA	[TEXT]
<input type="checkbox"/> Multidisciplinary care plan	[TEXT]
<input type="checkbox"/> Research and clinical trial participation	[TEXT]
<input type="checkbox"/> Riluzole	[TEXT]
<input type="checkbox"/> Vaccinations	[TEXT]
<input type="checkbox"/> Other [TEXT]	[TEXT]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Physical Examination

Status: Collected Not Collected

Reason not collected [TEXT]

Date of Exam: [DATE CONTROL]

Examiner's Initials: [TEXT]

PHYSICAL EXAMINATION					
Not Done	Area Tested	Normal	Abnormal and Not Clinically Significant	Abnormal and Clinically Significant	Comments
<input type="checkbox"/>	General appearance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	HEENT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	Respiratory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	Cardiovascular	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	Gastrointestinal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	Genito-urinary	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	Neurological	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	Musculoskeletal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	Lymph Nodes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	Other [TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	Other [TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]
<input type="checkbox"/>	Other [TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[TEXT]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Pulmonary Function Tests

Status Collected Not Collected

Reason not collected [TEXT]

Date Performed: [DATE CONTROL]

Evaluator's Initials [TEXT]

Forced Vital Capacity				
Position Unknown	Position	Patient Liters	Predicted	% Predicted
<input type="checkbox"/>	Upright	[NUMERIC]	[NUMERIC]	[AUTO-CALCULATED] %
	Supine	[NUMERIC]	[NUMERIC]	[AUTO-CALCULATED] %

Slow Vital Capacity				
Position Unknown	Position	Patient Liters	Predicted	% Predicted
<input type="checkbox"/>	Upright	[NUMERIC]	[NUMERIC]	[AUTO-CALCULATED] %
	Supine	[NUMERIC]	[NUMERIC]	[AUTO-CALCULATED] %

Maximum Inspiratory Pressure		
Position Unknown	Position	Patient cm of H ₂ O
<input type="checkbox"/>	Upright	[NUMERIC]
	Supine	[NUMERIC]

Maximal Voluntary Ventilation		
Position Unknown	Position	Patient cm of H ₂ O
<input type="checkbox"/>	Upright	[NUMERIC]
	Supine	[NUMERIC]

SNIP (Sniff Nasal Inspiratory Pressure)		
Position Unknown	Position	Patient cm of H ₂ O
<input type="checkbox"/>	Upright	[NUMERIC]
	Supine	[NUMERIC]

Maximum Expiratory Pressure		
Position Unknown	Position	Patient cm of H ₂ O
<input type="checkbox"/>	Upright	[NUMERIC]
	Supine	[NUMERIC]

Peak Inspiratory Flow Rate		
Position Unknown	Position	Patient cm of H ₂ O
<input type="checkbox"/>	Upright	[NUMERIC]
	Supine	[NUMERIC]

Peak Expiratory Flow Rate

Position Unknown	Position	Patient cm of H ₂ O
<input type="checkbox"/>	Upright	[NUMERIC]
	Supine	[NUMERIC]

Forced Expiratory Volume In 1 Second (FEV1)

Position Unknown	Position	Patient Liters	Predicted	% Predicted
<input type="checkbox"/>	Upright	[NUMERIC]	[NUMERIC]	[AUTO-CALCULATED] %
	Supine	[NUMERIC]	[NUMERIC]	[AUTO-CALCULATED] %

Forced Expiratory Volume In 6 Second (FEV6)

Position Unknown	Position	Patient Liters	Predicted	% Predicted
<input type="checkbox"/>	Upright	[NUMERIC]	[NUMERIC]	[AUTO-CALCULATED] %
	Supine	[NUMERIC]	[NUMERIC]	[AUTO-CALCULATED] %

Single Breath Count

Position Unknown	Position	Patient cm of H ₂ O
<input type="checkbox"/>	Upright	[NUMERIC]
	Supine	[NUMERIC]

Sniff test (bedside)

- Normal
- Slightly Decreased
- Very Weak or Nil
- Inverted

Mask or mouth seal used? Yes No

Other pulmonary testing:

- Not recommended
- Nocturnal oximetry
- Polysomnogram
- Other pulmonary test: [TEXT]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Safety Labs - Chemistry

Status: Collected Not Collected

Reason not collected [TEXT]

Date Drawn: [DATE CONTROL]

CHEMISTRY					
<u>Type</u>	<u>Units</u>	<u>Results</u>	<u>Normal</u>	<u>Abnormal and Not Clinically Significant</u>	<u>Abnormal and Clinically Significant</u>
SGPT (ALT)	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SGOT (AST)	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Albumin	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alkaline Phosphatase	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BUN	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Calcium	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chloride	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Creatinine	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Glucose	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Potassium	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sodium	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Total Bilirubin	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Total Protein	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 1: [TEXT]	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 2: [TEXT]	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 3: [TEXT]	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Safety Labs - Hematology

Status: Collected Not Collected

Reason not collected [TEXT]

Date Drawn: [DATE CONTROL]

HEMATOLOGY					
<u>Type</u>	<u>Units</u>	<u>Results</u>	<u>Normal</u>	<u>Abnormal and Not Clinically Significant</u>	<u>Abnormal and Clinically Significant</u>
CBC (With Diff)					
Hemoglobin	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hematocrit	%	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Total RBC	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MCV	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MCH	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MCHC	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Platelet count	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Total WBC count	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neutrophils	%	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lymphocytes	%	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Monocytes	%	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eosinophils	%	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Basophils	%	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 1: [TEXT]	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 2: [TEXT]	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 3: [TEXT]	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Safety Labs - Pregnancy Test

Status: Collected Not Collected

Reason not collected [TEXT]

Date Drawn: [DATE CONTROL]

Test Type: Serum Urine

<u>Type</u>	<u>Results</u>
hCG	<input type="radio"/> Positive <input type="radio"/> Negative

Safety Labs - Urinalysis

Status: Collected Not Collected

Reason not collected [TEXT]

Date Drawn: [DATE CONTROL]

URINALYSIS					
<u>Type</u>	<u>Units</u>	<u>Results</u>	<u>Normal</u>	<u>Abnormal and Not Clinically Significant</u>	<u>Abnormal and Clinically Significant</u>
Albumin	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bilirubin	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clarity	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Color	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Glucose	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ketones	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nitrites	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PH	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Protein	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specific Gravity	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urobilinogen	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WBCs	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 1: [TEXT]	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 2: [TEXT]	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other 3: [TEXT]	[TEXT]	[TEXT]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cerebrospinal Fluid (CSF) Sample

Status: Collected Not Collected

Reason not collected [TEXT]

Date CSF Sample Collected [DATE CONTROL]

Collector's Initials [TEXT]

Collection number [NUMERIC]

Time Collected:	[NUMERIC] : [NUMERIC] (24hr clock)
Pre-centrifugation sample appearance	<input type="radio"/> Clear <input type="radio"/> Pink <input type="radio"/> Cloudy <input type="radio"/> Other [TEXT]
Time started centrifugation:	[NUMERIC] : [NUMERIC] (24hr clock)
Speed of centrifugation:	[NUMERIC] x g (times gravity)
Duration of centrifugation:	[NUMERIC] minutes
Post-centrifugation sample appearance	<input type="radio"/> Clear <input type="radio"/> Pink <input type="radio"/> Cloudy <input type="radio"/> Other [TEXT]
Time aliquoted:	[NUMERIC] : [NUMERIC] (24hr clock)
Time aliquots put on dry ice:	[NUMERIC] : [NUMERIC] (24hr clock) <input type="checkbox"/> N / A
Time aliquots put in -70C or -80C freezer:	[NUMERIC] : [NUMERIC] (24hr clock)

<input type="checkbox"/>	Number of aliquots	Aliquot volume	Units	Volume of last aliquot
--------------------------	--------------------	----------------	-------	------------------------

Remove Line

Add Line

When adding a line

Sample Collection Record

Number of full aliquots [NUMERIC]

Volume of aliquots [NUMERIC] [DROP-DOWN MENU: ml, µl]

Volume of last aliquot if less than volume specified above [NUMERIC]

Serum Sample

Status: Collected Not Collected

Reason not collected [TEXT]

Date collected: [DATE CONTROL]

Collector's Initials [TEXT]

Collection number [NUMERIC]

Time Collected:	[NUMERIC] :[NUMERIC] (24hr clock)
Time started centrifugation:	[NUMERIC] :[NUMERIC] (24hr clock)
Speed of centrifugation:	[NUMERIC] x g (times gravity)
Duration of centrifugation:	[NUMERIC] minutes
Time aliquoted:	[NUMERIC] :[NUMERIC] (24hr clock)
Time aliquots put on dry ice:	[NUMERIC] :[NUMERIC] (24hr clock) <input type="checkbox"/> N / A
Time aliquots put in -70C or -80C freezer:	[NUMERIC] :[NUMERIC] (24hr clock)
Did serum remain pink after centrifugation (indicates hemolysis)?	<input type="radio"/> Yes <input type="radio"/> No

<input type="checkbox"/>	Number of aliquots	Aliquot volume	Units	Volume of last aliquot
--------------------------	--------------------	----------------	-------	------------------------

Remove Line

Add Line

When adding a line

Sample Collection Record

Number of full aliquots [NUMERIC]

Volume of aliquots [NUMERIC] [DROP-DOWN MENU: ml, µl]

Volume of last aliquot if less than volume specified above [NUMERIC]

Plasma Sample

Status: Collected Not Collected

Reason not collected [TEXT]

Date collected: [DATE CONTROL]

Collector's Initials [TEXT]

Collection number [NUMERIC]

Time Collected:	[NUMERIC] :[NUMERIC] (24hr clock)
Time started centrifugation:	[NUMERIC] :[NUMERIC] (24hr clock)
Speed of centrifugation:	[NUMERIC] x g (times gravity)
Duration of centrifugation:	[NUMERIC] minutes
Time aliquoted:	[NUMERIC] :[NUMERIC] (24hr clock)
Time aliquots put on dry ice:	[NUMERIC] :[NUMERIC] (24hr clock) <input type="checkbox"/> N / A
Time aliquots put in -70C or -80C freezer:	[NUMERIC] :[NUMERIC] (24hr clock)
Did plasma remain pink after centrifugation (indicates hemolysis)?	<input type="radio"/> Yes <input type="radio"/> No

<input type="checkbox"/>	Number of aliquots	Aliquot volume	Units	Volume of last aliquot
--------------------------	--------------------	----------------	-------	------------------------

Remove Line

Add Line

When adding a line

Sample Collection Record

Number of full aliquots [NUMERIC]

Volume of aliquots [NUMERIC] [DROP-DOWN MENU: ml, µl]

Volume of last aliquot if less than volume specified above [NUMERIC]

Whole Blood Sample

Status Collected Not Collected

Reason not collected [TEXT]

Date drawn [DATE CONTROL]

Collector's Initials [TEXT]

Collection number [NUMERIC]

Number of tubes collected [NUMERIC]

Sample Collection Questionnaire

Status Collected Not Collected

Reason not collected [TEXT]

Date drawn [DATE CONTROL]

Collector's Initials [TEXT]

Did the volunteer consume any caffeinated beverages (coffee, tea, soda) on the day of sample collection?

Yes No

On average, how many caffeinated beverages (coffee, tea, soda) does volunteer consume in a week?

[NUMERIC] /week

Did the volunteer consume any food prior to sample collection?

Yes No

Time of last meal: [NUMERIC] : [NUMERIC] (24-hour clock)

Post LP Phone Call

Was the phone call completed? Yes No

If Yes, date of phone call: [DATE CONTROL]

If No, reason: [TEXT]

Did the patient have any post-lumbar puncture adverse events?

Yes No

If Yes, please update the *Adverse Event* or *Clinical Milestones* log

If the patient had a post-lumbar puncture adverse event (i.e., headache), did the patient receive a caffeine drip treatment? Yes No

If the patient had a post-lumbar puncture adverse event (i.e., headache), did the patient receive a blood patch?

Yes No

Skin Biopsy Procedure

Status Collected Not Collected

Reason not collected [TEXT]

Date drawn [DATE CONTROL]

Collector's Initials [TEXT]

Diameter of biopsy site: [NUMERIC] mm

Site of Biopsy

Right Left

Upper Leg

Upper Arm

Other: [TEXT]

Time (months) between symptom onset and date of biopsy: [NUMERIC]

Timed Reading of Test Paragraph

Status: Collected Not Collected

Reason not collected [TEXT]

Date performed: [DATE CONTROL]

Evaluator's Initials: [DATE CONTROL]

Did the subject read for 60 seconds? Yes No

If yes, number of words read: [NUMERIC] words

If no, time spent reading: [NUMERIC] seconds

Number of words read: [NUMERIC] words

Did the subject complete the entire passage? Yes No

If yes, time spent reading [NUMERIC] seconds

Speech evaluation:			
Characteristic	Normal	Abnormal	Comments
Loudness	<input type="radio"/>	<input type="radio"/>	[TEXT]
Nasality	<input type="radio"/>	<input type="radio"/>	[TEXT]
Intelligibility	<input type="radio"/>	<input type="radio"/>	[TEXT]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Timed Swallowing Solids Test

Status: Collected Not Collected

Reason not collected [TEXT]

Date performed: [DATE CONTROL]

Evaluator's Initials: [DATE CONTROL]

Test Number	Test Status	Swallowing Time* (seconds)	Comments
1	<input type="radio"/> Not done/did not attempt	[NUMERIC]	[TEXT]
	<input type="radio"/> Started test but did not complete		
	<input type="radio"/> Finished test to completion		
2	<input type="radio"/> Not done/did not attempt	[NUMERIC]	[TEXT]
	<input type="radio"/> Started test but did not complete		
	<input type="radio"/> Finished test to completion		
3	<input type="radio"/> Not done/did not attempt	[NUMERIC]	[TEXT]
	<input type="radio"/> Started test but did not complete		
	<input type="radio"/> Finished test to completion		
Average swallowing time: [NUMERIC]			

* To calculate swallowing time, begin recording when the patient is told to chew and end recording when the subject's larynx comes to rest.

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Timed Swallowing Water Test

Status: Collected Not Collected

Reason not collected [TEXT]

Date performed: [DATE CONTROL]

Evaluator's Initials: [DATE CONTROL]

Test Number	Test Status	Swallowing Time* (seconds)	Comments (required if not done)
1	<input type="radio"/> Not done/did not attempt	[NUMERIC]	[TEXT]
	<input type="radio"/> Started test but did not complete		
	<input type="radio"/> Finished test to completion		
2	<input type="radio"/> Not done/did not attempt	[NUMERIC]	[TEXT]
	<input type="radio"/> Started test but did not complete		
	<input type="radio"/> Finished test to completion		
Average swallowing time: [NUMERIC]			

Swallowing evaluation			
Symptom	Finding		Comments
Choking	<input type="radio"/> Present	<input type="radio"/> Absent	[TEXT]
Spillage	<input type="radio"/> Yes	<input type="radio"/> No	[TEXT]
Effort	<input type="radio"/> Abnormal	<input type="radio"/> Normal	[TEXT]

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]

Visit Summary

Visit Summary		
Specialist	Seen	Referred
Dietician/nutritionist	<input type="checkbox"/>	<input type="checkbox"/>
Durable medical equipment vendor	<input type="checkbox"/>	<input type="checkbox"/>
Genetic counselor	<input type="checkbox"/>	<input type="checkbox"/>
Geneticist	<input type="checkbox"/>	<input type="checkbox"/>
Neurologist	<input type="checkbox"/>	<input type="checkbox"/>
Neuropsychologist	<input type="checkbox"/>	<input type="checkbox"/>
Nurse practitioner	<input type="checkbox"/>	<input type="checkbox"/>
Occupational therapist	<input type="checkbox"/>	<input type="checkbox"/>
Orthotic expert	<input type="checkbox"/>	<input type="checkbox"/>
Palliative care specialist	<input type="checkbox"/>	<input type="checkbox"/>
Patient advocacy representative	<input type="checkbox"/>	<input type="checkbox"/>
Physiatrist/PMR	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapist	<input type="checkbox"/>	<input type="checkbox"/>
Physician assistant	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonologist	<input type="checkbox"/>	<input type="checkbox"/>
Research coordinator	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory therapist	<input type="checkbox"/>	<input type="checkbox"/>
Seating specialist	<input type="checkbox"/>	<input type="checkbox"/>
Social worker	<input type="checkbox"/>	<input type="checkbox"/>
Speech language pathologist	<input type="checkbox"/>	<input type="checkbox"/>
Other: [TEXT]	<input type="checkbox"/>	<input type="checkbox"/>

Vital Signs

Status: Collected Not Collected

Reason not collected [TEXT]

Date performed: [DATE CONTROL]

Evaluator's Initials: [DATE CONTROL]

Test	Measurement	Unit	Measurement Specification	Additional Specifications
Temperature	[NUMERIC]	<input type="radio"/> F <input type="radio"/> C	Method: <input type="radio"/> Axillary <input type="radio"/> Oral <input type="radio"/> Rectal <input type="radio"/> Tympanic <input type="radio"/> Other (specify): [TEXT]	
Blood Pressure (Systolic/ Diastolic)	[NUMERIC] / [NUMERIC]	mmHg	Position: <input type="radio"/> Standing <input type="radio"/> Sitting <input type="radio"/> Supine	Arm used: <input type="radio"/> Left <input type="radio"/> Right
Heart rate	[NUMERIC]	beats / min		
Respiratory rate	[NUMERIC]	breaths / min		
Weight	[NUMERIC]	<input type="radio"/> lb <input type="radio"/> kg		
Height	[NUMERIC]	<input type="radio"/> in <input type="radio"/> cm		
BMI	[NUMERIC]			

Data Source

- medical records
- original collection
- patient reported
- unknown
- other [TEXT]