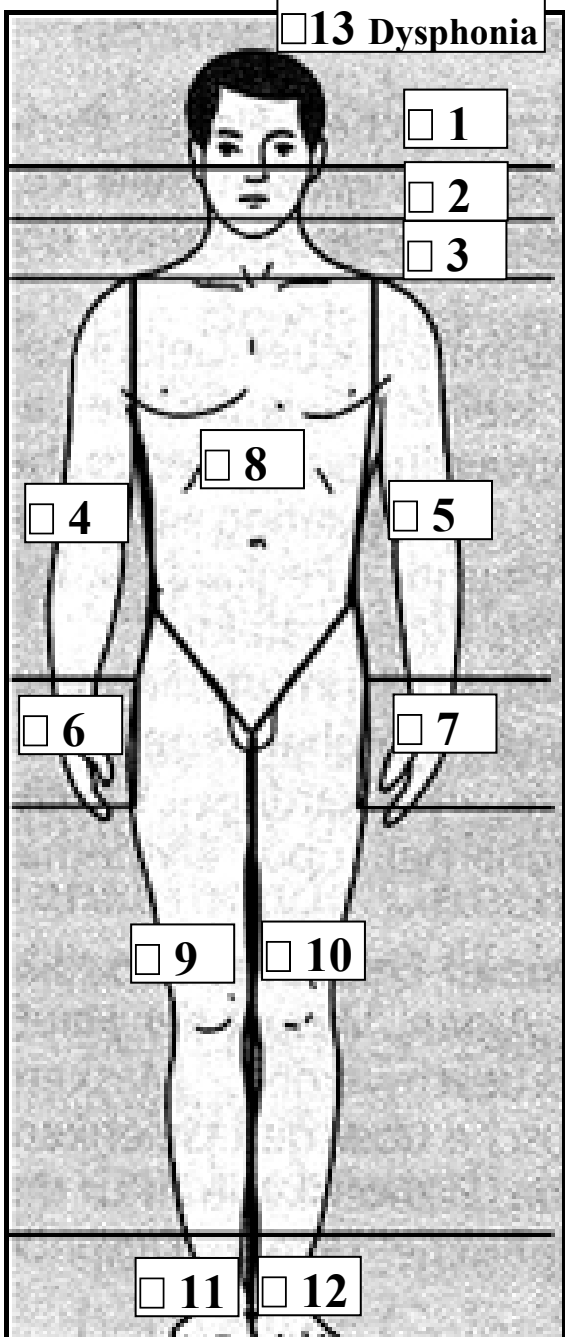


Dystonia Intake Form

<p>Patient's label or identity details:</p> <p>Name (Last, First):</p> <p>ID #:</p> <p>Date of birth:</p> <hr/> <p>Sex: <input type="checkbox"/> male <input type="checkbox"/> female</p> <p>Status: <input type="checkbox"/> affected <input type="checkbox"/> healthy</p> <p>Dystonia: <input type="checkbox"/> definite <input type="checkbox"/> probable <input type="checkbox"/> possible <input type="checkbox"/> no dystonia</p> <p><u>Symptoms at onset:</u></p> <p>Site:</p> <p>Age:</p> <p><u>Distribution at examination:</u> (choose one box and tick involved areas on figure)</p> <p><input type="checkbox"/> Generalized (= two or more body segments including the lower extremities)</p> <p><input type="checkbox"/> Hemidystonia (= strictly confined to single side of body)</p> <p><input type="checkbox"/> Multifocal (= two or more non-contiguous body regions)</p> <p><input type="checkbox"/> Segmental (= two or more contiguous body regions)</p> <p><input type="checkbox"/> Focal (= one involved body part)</p> <p><u>Associated features: (may choose more than one)</u></p> <p><input type="checkbox"/> Rapid onset</p> <p><input type="checkbox"/> Diurnal Fluctuation</p> <p><input type="checkbox"/> Dystonia plus (other neurologic features)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Myoclonus</p> <p style="margin-left: 20px;"><input type="checkbox"/> Postural/Action Tremor</p> <p style="margin-left: 20px;"><input type="checkbox"/> Intention Tremor</p> <p style="margin-left: 20px;"><input type="checkbox"/> Parkinsonism</p> <p style="margin-left: 20px;"><input type="checkbox"/> other (specify)</p>	<div style="text-align: center; font-weight: bold; font-size: 1.2em;">Dystonia</div> 
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Dystonia Intake Form

Alcohol-responsive: yes _____%improvement no not tested
 Dopa-responsive: yes _____%improvement no not tested

Past Medical History Considered by Investigator as Possibly Associated with Dystonia
 (may choose more than one):

<input type="checkbox"/> Anoxia/ complicated pregnancy or delivery	<input type="checkbox"/> Trauma- brain
<input type="checkbox"/> CVA (cerebrovascular accident)	<input type="checkbox"/> Trauma – peripheral
<input type="checkbox"/> Infection	<input type="checkbox"/> Neuropathy in area of dystonia (eg. ulnar)
<input type="checkbox"/> Tumor	<input type="checkbox"/> General anesthesia
<input type="checkbox"/> Mitochondrial disorder	<input type="checkbox"/> Neuroleptic/Dopamine-antagonist exposure (specify drug, if possible)
<input type="checkbox"/> Heredodegenerative / metabolic disorder (specify)	

Family history of Movement Disorders (e.g. dystonia, myoclonus, tremor, parkinsonismus, etc.)

<input type="checkbox"/> Positive	<input type="checkbox"/> Possible	<input type="checkbox"/> Negative	<input type="checkbox"/> Unknown
Please attach pedigree here, if there is a “positive” or “possible” family history and specify symptoms of relatives			

Classification of Dystonia:

<input type="checkbox"/> Primary (dystonia the only feature) <hr/> <input type="checkbox"/> Primary plus (other features) <input type="checkbox"/> Myoclonus-dystonia <input type="checkbox"/> Dopa-responsive dystonia <input type="checkbox"/> Dystonia-Parkinsonism <input type="checkbox"/> Paroxysmal dystonia <input type="checkbox"/> other (specify)	<input type="checkbox"/> Secondary <input type="checkbox"/> Tardive <input type="checkbox"/> other (specify) <hr/> <input type="checkbox"/> Heredodegenerative (specify, if known)
<input type="checkbox"/> Unable to definitely classify	<input type="checkbox"/> Asymptomatic Relative

Referred by Name (Last, First)	Institution/Hospital	Date	Signature