CPUP – Adult

National health care programme for adults with cerebral palsy

(If this is the first CPUP assessment, replace “since the last assessment” by “during the last year”)

Personal ID Number (year-month-day-xxxx) ________________________________

Surname_______________________**First name**_____________________________

Form of housing____

Assistant **No** ☐ **Yes** ☐ (if yes, hours/week) ____________________________

Interpreter **No** ☐ **Yes** ☐ (if yes, language) ______________________________

Employment/Studies/Occupation ____

Singel ☐ **Live-apart** ☐ **Partner** ☐ **Married** ☐ **Number of children** ________

County, state of residence ____

Residential district ____

Assessment date (year-month-day)____

Assessment carried out by ____

Assessor's workplace____

CP subtype

Spastic unilateral ☐ Right side weakness ☐ Left side weakness ☐

Spastic bilateral ☐

Ataxic ☐

Dyskinetic ☐

Unclassified/mixed type ☐ Comments __________________________________

Manual Ability Classification System (MACS) I ☐ II ☐ III ☐ IV ☐ V ☐

Gross Motor Function Classification System E&R I ☐ II ☐ III ☐ IV ☐ V ☐

Active joint range of motion (ROM) – performed in sitting

	Right	Left
Can reach the neck with the hand	No □ Yes □	No □ Yes □
Can reach the mouth with the hand	No □ Yes □	No □ Yes □
Can reach the lower back with the hand	No □ Yes □	No □ Yes □
Can supinate the hand actively	No □ Yes □	No □ Yes □
Active supination, ROM	_________ °	_________ °

Passive joint range of motion (ROM) – performed in supine

	Right	Left	Differs from standardized position (supine) If yes, note position
Shoulder			
Abduction	____°	____°	Yes □ ________________
Flexion	____°	____°	Yes □ ________________
External rotation	____°	____°	Yes □ ________________
Internal rotation	____°	____°	Yes □ ________________
Elbow			
Extension	____°	____°	Yes □ ________________
Flexion	____°	____°	Yes □ ________________
Supination	____°	____°	Yes □ ________________
Pronation	____°	____°	Yes □ ________________
Wrist			
Extension (flexed fingers)	____°	____°	Yes □ ________________
Extension (straight fingers)	____°	____°	Yes □ ________________
Flexion	____°	____°	Yes □ ________________
Ulnar deviation	____°	____°	Yes □ ________________
Radial deviation	____°	____°	Yes □ ________________
Hip			
Abduction	____°	____°	Yes □ ________________
Internal rotation	____°	____°	Yes □ ________________
External rotation	____°	____°	Yes □ ________________
Flexion	____°	____°	Yes □ ________________
Extension	____°	____°	Yes □ ________________
Knee			
Popliteal angle (Straight knee = 180°)	____°	____°	Yes □ ________________
Flexion	____°	____°	Yes □ ________________
Extension (Straight knee = 0°)	____°	____°	Yes □ ________________
Ankle			
Dorsiflexion (flexed knee)	____°	____°	Yes □ ________________
Dorsiflexion (extended knee)	____°	____°	Yes □ ________________

Assessment - feet

Cannot put weight onto feet □ Can put weight onto feet right □ left □ both □

Right heel, when weight bearing:
Normal □ Varus □ Valgus □

Left heel, when weight bearing:
Normal □ Varus □ Valgus □

Comments____

Spasticity/Muscle tone

Scissoring when walking/during activity none ☐ mild ☐ pronounced ☐
Scissoring at rest none ☐ mild ☐ pronounced ☐

	Right	Left
Foot clonus	No ☐ Yes ☐	No ☐ Yes ☐
Hand clonus	No ☐ Yes ☐	No ☐ Yes ☐
Spasticity in wrist, finger flexors	No ☐ Yes ☐	No ☐ Yes ☐

Assessment of muscle tone at rest according to the Modified Ashworth Scale (see manual)
0 = No increase in muscle tone.
1 = Slight increase in tone with a catch and release or minimal resistance at end of range.
+1 = As 1 but with minimal resistance through range following catch.
2 = More marked increase in tone through ROM.
3 = Considerable increase in tone, passive movement difficult.
4 = Affected part rigid.

	Right						**Left**					
	0	**1**	**+1**	**2**	**3**	**4**	**0**	**1**	**+1**	**2**	**3**	**4**
Elbow flexors	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adductors	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Knee flexors	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Plantar flexors	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments____

Tumb

	Right	Left
Tenseness at volar abduction	No ☐ Yes ☐	No ☐ Yes ☐
Thumb in palm	No ☐ Yes ☐	No ☐ Yes ☐
Classification of thumb-in-palm according to House Typ I-IV	__________	__________

Comments____

Simultaneous wrist and finger extension

According to Zancolli, group 1+X, 1, 2A, 2B or 3 Right _________ Left __________

Wrist or finger extension could not be assessed according to Zancolli Right ☐ Left ☐

Comments____

Functional classification according to House 0–8 Right ______ Left ______

Dominant hand (preferred hand) Right ☐ Left ☐ Both ☐

Bimanual ability No ☐ Yes ☐

Comments ____

Lying – most frequent resting and sleeping posture (Several options may be chosen)

		Hours/day spent in lying
Supine lying	☐	
Prone lying	☐	< 8 ☐
Side lying, right side	☐	8–12 ☐
Side lying, left side	☐	> 12 ☐
Other resting/sleeping posture	☐	

Maintains a lying posture: Independently ☐ Needs assistance/support ☐

Changes position in lying: Independently ☐ Can assist ☐ Needs total assistance ☐

Uses positioning equipment when lying : No ☐ Yes ☐

Positioning rolls, cushions ☐ Adjustable bed ☐ Sleeping system ☐ Other☐

Comments ____

Assessment – supine lying (adapted from MPD 24-7, with kind permission from P M Pope)

Head midline	No ☐	Yes ☐
Trunk symmetrical	No ☐	Yes ☐
Legs straight relative to pelvis	No ☐	Yes ☐
Legs separated	No ☐	Yes ☐
Arms resting by side	No ☐	Yes ☐
Weight evenly distributed	No ☐	Yes ☐

Comments ____

Sitting – performance (most common)
(Several options may be chosen such as moulded seat and wheelchair)

Cannot be placed in a sitting position	☐
Moulded seat	☐
Wheelchair (tilt in space)	☐
Wheelchair (without tilt in space)	☐
Adaptive seating, modular chair	☐
Regular chair	☐
Other option	☐ What?_________________________________

Hours/ day spent in sitting <8 ☐ 8–12 ☐ >12 ☐

Comments ____

Assessment – sitting on a plinth (adapted from MPD 24-7, with kind permission from P M Pope)

Head midline	No ☐	Yes ☐
Trunk symmetrical	No ☐	Yes ☐
Legs separated and in neutral position	No ☐	Yes ☐
Arms resting by side	No ☐	Yes ☐
Both feet flat on floor	No ☐	Yes ☐
Weight evenly distributed	No ☐	Yes ☐

Assessed in: Unsupported sitting ☐ Supported sitting ☐

Comments ____

Assessment – spine

Scoliosis surgery No ☐ Yes ☐ (if yes, assessment below not obligatory)

Scoliosis present No ☐ Yes ☐

	Right	**Left**
Thoracic	convex ☐	convex ☐
Thoracolumbal	convex ☐	convex ☐
Lumbal	convex ☐	convex ☐

Scoliosis correctable ☐ fixed ☐

Scoliosis considered to be mild ☐ moderate ☐ pronounced☐

Assessed in standing ☐ sitting on a plinth ☐ lying ☐

Comments____

Spinal brace/jacket

Uses spinal brace? No ☐ Yes ☐

Soft brace ☐
Semi–soft brace ☐
Firm brace ☐

Average use, hours/ day < 6 ☐ 6–10 ☐ > 10 ☐

Does the brace have intended effect? No ☐ Yes ☐

If not, why?____

Sit to stand and stand to sit – **performance (most common)**
Without support (includes support against the child's own body, such as hands on knees).
With support (includes all external support or assisstance such as walls, furniture, persons).

	Without support	With support	Cannot
Floor-sitting to standing	☐	☐	☐
Standing to floor-sitting	☐	☐	☐
Chair-sitting to standing	☐	☐	☐
Standing to chair -sitting	☐	☐	☐

Standing – performance (most common)

Not standing ☐
Standing with aids/support (includes support from furniture or walls) ☐
Standing without aids (includes support against the child's own body) ☐

Uses standing aids	No ☐	Yes ☐		
Days per week:	1–2 ☐	3–4 ☐	5–6 ☐	7 ☐
Times per day:	1 ☐	2 ☐	3 ☐	>3 ☐
Hours per day:	<1 ☐	1–2 ☐	3–4 ☐	>4 ☐

Type of standing aid (several options may be chosen i.e tilt table and standing brace):
Tilt table/Standing frame ☐ Standing brace ☐ Standing wheelchair ☐ Other ☐

Standing aids used together with Orthoses ☐ Spinal brace/jacket ☐

Comments ____

Assessment – standing (adapted from MPD 24-7, with kind permission from P M Pope)

Head midline	No ☐	Yes ☐
Trunk symmetrical	No ☐	Yes ☐
Legs straight, hips and knees extended	No ☐	Yes ☐
Legs separated	No ☐	Yes ☐
Both feet flat on floor	No ☐	Yes ☐
Weight evenly distributed	No ☐	Yes ☐

Assessed in: Unsupported standing ☐ Supported standing ☐

Comments ____

Transfers (short transfers i.e. toilet or bed)

Transfers independently ☐
Stands with support ☐
Sitting, side transfer ☐
Uses hoist and sling ☐

Comments________________________________

Mobility – stairs

Walks up stairs		**Walks down stairs**	
Without support	☐	Without support	☐
Handrail	☐	Handrail	☐
Person assisting	☐	Person assisting	☐
Person assisting + handrail	☐	Person assisting+ handrail	☐
Cannot	☐	Cannot	☐

Comments________________________________

Functional Mobility Scale (FMS)

Ask the person to rate the most frequent mobility method for all three distances. FMS is a performance measure, rate what the person actually does. Note one score for each distance.

_________ 5 metres _________ 50 metres _________ 500 metres

N= Does not apply:eg, does not complete the distance.
C= Crawling: crawls for mobility at home (5 m).
1= Uses wheelchair: may stand for transfers, may do some stepping supported by another person or using a walker/frame.
2= Uses a walker or frame: without help from another person.
3= Uses crutches: without help from another person.
4= Uses sticks (one or two): without help from another person.
5= Independent on level surfaces: Does not use walking aids or need help from another person.* Requires a rail for stairs. *If uses furniture, walls, fences, shop fronts for support, please use 4 as the appropriate description.
6= Independent on all surfaces: Does not use any walking aids or need any help from another person when walking over all surfaces including uneven ground, curbs etc. and in a crowded environment.

Mobility – wheelchairs

Indoors – performance (complementary to the FMS)

Manual wheelchair:	Does not use ☐	Attendant pushed ☐	Self-propels ☐
Powered wheelchair:	Does not use ☐	Attendant operated ☐	Self-operates ☐

Outdoors – performance (complementary to the FMS)

Manual wheelchair:	Does not use ☐	Attendant pushed ☐	Self-propels ☐
Powered wheelchair:	Does not use ☐	Attendant operated ☐	Self-operates ☐

Comments________________________________

Pain

Reported by the person ☐ Reported by a proxy ☐

Does the person or a proxy experience that the person has pain? No ☐ Yes ☐

If yes, **where and how much** aich or pain did you have during the last four weeks?

	None	Very mild	Mild	Moderate	Severe	Very severe
Head	☐	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐	☐
Back	☐	☐	☐	☐	☐	☐
Shoulders	☐	☐	☐	☐	☐	☐
Arms, hands	☐	☐	☐	☐	☐	☐
Hips	☐	☐	☐	☐	☐	☐
Knees	☐	☐	☐	☐	☐	☐
Feet	☐	☐	☐	☐	☐	☐
Teeth	☐	☐	☐	☐	☐	☐
Stomach	☐	☐	☐	☐	☐	☐
Skin, pressure	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

If other, please specify ____

If yes: How much did your aich and pain **affect your normal work** during the last four weeks? (includes work outside the home and daily activities)

Not at all ☐
Slightly ☐
Moderatly ☐
Considerably ☐
Very much ☐

Comments ____

Nutritional status

Height _______________ **cm** **Weight**________________ **kg**

Uncertain/difficult to measure No ☐ Yes ☐
Standing ☐
Lying, measurement board ☐
Lying, measurment tape ☐
Reported by person/proxy ☐

Standing (bathroom scale) ☐
Chair scale ☐
Lift scale ☐
In someone's arms ☐
Reported by person/proxy ☐

Skinfold thickness at the level of the umbilicus, straight under the nipple

< 0.5 cm ☐ (almost total lack of subcutaneous fat)
> 0.5 cm ☐ (some subcutaneous fat on the trunk)

Gastrostomy No ☐ Yes ☐

Comments____

Orthoses (Several options may be reported)

Does the person use orthoses for upper or lower extremities? No ☐ Yes ☐

Type	For function Right	For function Left	Contracture prevention Right	Contracture prevention Left	Average use, hours/day < 6	Average use, hours/day > 6
1 AFO day	☐	☐	☐	☐	☐	☐
2 AFO night	☐	☐	☐	☐	☐	☐
3 Other type__________	☐	☐	☐	☐	☐	☐
4 Other type__________	☐	☐	☐	☐	☐	☐

Does the orthosis function as intended?
Yes ☐ Orthosis number _______________ No☐ Orthosis number _______________

Why?____

Have skin irritation/ sores appeared in connection with the use of the orthosis? No ☐
Yes ☐ Orthosis number ____________

Fracture

Has the person had any fractures since the last assessment? No ☐ Yes☐

If yes, where?____

Surgery or treatment to reduce spasticity

Has the person had any **surgery** since the last assessment? No ☐ Yes ☐

If yes, please specify what surgery? Date

______________________________ ____________________

______________________________ ____________________

______________________________ ____________________

Has the person received any **Botulinum toxin injections** since the last assessment? No ☐ Yes ☐

If yes, please specify which muscles? Date

______________________________ ____________________

______________________________ ____________________

______________________________ ____________________

Has the person conducted or been helped to implement **training programmes** post–botox or post–surgery No ☐ Yes ☐

Does the person have a **Baclofen pump**? No ☐ Yes ☐

Radiographic examinations

When was the last radiograph of the hips? ___________ Where? ___________ Unknown/None ☐

When was the last radiograph of the spine? __________ Where? ___________ Unknown/None ☐

Treatment/training

Since the last assessment, has the person conducted/been assisted to perform activities/training for:

Reduced pain	No ☐	Yes ☐
Joint range of motion	No ☐	Yes ☐
Muscle strength	No ☐	Yes ☐
Oxygen uptake/Endurance	No ☐	Yes ☐
Postural ability (balance, stability)	No ☐	Yes ☐
Mobility	No ☐	Yes ☐
Hand function	No ☐	Yes ☐
Personal care	No ☐	Yes ☐
Communication	No ☐	Yes ☐
Cognition	No ☐	Yes ☐

Comments ____

Has the person specified any aims/goals for the training in consultation with a:

Physiotherapist ? No ☐ Yes ☐ Occupational therapist? No ☐ Yes ☐

Comments ____

Physical activities

Has the person participated in/ performed physical activities/sports regularly, since the last assessment? No ☐ Yes ☐

If yes, how often? < 1 time/week ☐ 1–2 times/week ☐ 3–5 times/week ☐

Which physical activities/leisures?

Walking ☐	Nordic walking ☐	Biking ☐	Swimming/water activities ☐
Fotboll ☐	Strength training ☐	Dancing ☐	Horseback riding ☐
Gymnastics ☐	Skiing ☐	Skating ☐	Sledge hockey ☐
Orienteering ☐	Basket ball ☐	Bowling ☐	Boccia/Boules ☐

Other____

Did the CPUP assessment lead to any suggested interventions? (Please specify)

Other comments