Modified with W. Lo, G. deVeber and R. Ichord March 8, 2006
Revision May 2, 2006

IPSS Recovery and Recurrence Questionnaire

IPSS ID# _____ **Site:** _____ **Date of assessment:** Year____ Month___ Day___

Method of Administration: ☐ Parent interview in clinical setting ☐ Mail-out ☐ Telephone ☐ Chart review

Person administering questionnaire: _____

Note: If child has died since discharge from hospital, please go directly to item 8 (skip items 1-7)

Q1. Has your child recovered completely from the stroke? ☐ Yes ☐ No
If no, please answer the following questions:

1A. Does your child have any problems with strength, coordination, or sensation including vision or hearing, as a result of the stroke? If yes, please choose which of the following are present in your child:

☐ Developmental delay
☐ Abnormal tone
☐ Weakness on one side of the body
☐ Weakness on one side of the face
☐ Unsteadiness on one side of the body
☐ Difficulty with hearing
☐ Difficulty with speaking clearly (problem with pronouncing words)
☐ Difficulty with drinking, chewing or swallowing
☐ Loss of sensation on one side of the body
☐ Other sensory problems
☐ Difficulty with vision

☐ Other problems with strength or coordination; Describe:_____

Does the problem affect your child's day-to-day activities? ☐ Yes ☐ No

	Right side face or body	Left side face or body
Not Done	n/t	n/t
None	0	0
Mild but no impact on function	0.5	0.5
Moderate with some limitations with daily functions	1	1
Severe or Profound with missing function	2	2

1B. Does your child have difficulty expressing him/herself verbally? (Exclude dysarthrias or pronunciation problems)

Not Done	n/t
None	0
Mild but no impact on function	0.5
Moderate with some limitations with daily functions	1
Severe or Profound with missing function	2

Please describe: _____

1C. Does your child have difficulty understanding what is said to her/him?

Not Done	n/t
None	0
Mild but no impact on function	0.5
Moderate with some limitations with daily functions	1
Severe or Profound with missing function	2

Please describe: _____

1D. Does your child have difficulty with his/her thinking or behavior?

Not Done	n/t
None	0
Mild but no impact on function	0.5
Moderate with some limitations with daily functions	1
Severe or Profound with missing function	2

Please describe: _____

TOTAL PARENTAL PSOM SCORE: _____/**10**

Q2. Does your child need extra help with day-to-day activities compared with other children of the same age? ☐ Yes ☐ No

Q3. Since the first stroke, has your child had another Stroke or Transient Ischemic Attack (TIA) or blood clot in any other blood vessel (e.g. in the leg, lung, heart, other location) ?
☐ Yes ☐ No ☐ Unknown

If yes, which *type*?
☐ Unknown
☐ Stroke in a brain artery (usual form of 'stroke')
☐ Stroke in a brain vein ('sinus thrombosis')
☐ TIA
☐ Other blood clot: (State location of blood clot :_____)

If yes, *when* was the recurrence (if unknown, please estimate)? Year_____ Month_____ Day____

Did your child have a *CT /MRI* at the time of the recurrence? ☐ Yes ☐ No ☐ Unknown
If yes, a) which test was done? ☐ CT ☐ MRI ☐ Unknown
b) did the CT /MRI show a new stroke? ☐ Yes ☐ No ☐ Unknown

Describe the **new** clinical symptoms at the time of the recurrence:
☐ Difficulty walking ☐ Difficulty using hand(s)
☐ Difficulty speaking ☐ Difficulty with vision
☐ Difficulty with drinking, chewing or swallowing ☐ Other, describe: _____

Describe how long the symptoms lasted with the most recent attack:
☐ Less than 6hrs ☐ 6-24 hours ☐ More than 24 hours

If there was more than one episode, how many episodes occurred?_____

What stroke treatment was he/she on at the beginning of the episode?
☐ None
☐ Aspirin
☐ Low Molecular Weight Heparin (Enoxaparin, Loxaprin, injections under the skin)
☐ Coumadin (blood thinning pill) ☐ Other (describe): _____

Q4. Does your child suffer from headaches or seizures since being discharged after the stroke(s)?
Headache: ☐ Yes ☐ No
Seizures: ☐ Yes ☐ No If yes is he/she on a seizure medicine now? ☐ Yes ☐ No

Q5. Have there been any other major health problems or procedures resulting from the stroke(s) or the stroke(s) treatment?
☐ Yes ☐ No
If yes, describe: _____

Q6. What medications are being used right now for stroke treatment?
☐ None
☐ Aspirin
☐ LMWH (blood thinner injected under the skin)
☐ Coumadin (blood thinner pill)
☐ Other (describe): _____

Q7. What rehabilitation treatments is your child receiving now?
☐ None
☐ Occupational Therapy
☐ Physical Therapy
☐ Speech therapy
☐ Special education services
☐ Other (describe): _____

Q8. If your child is deceased, please specify:
Date of death: Year_____ Month_____ Day____
Cause of death: _____

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Comprehensive Stroke Family History Questionnaire (Optional)

Instructions: Please answer the following questions as completely as possible.

1. **Has anyone in your child's family had a stroke?**
   a. ☐ No
   b. ☐ Yes

   How is the person related to your child (i.e. aunt, uncle, grandmother, etc. and on which side of the family, mothers or fathers) and at what age did they stroke? Please list all relatives who have had a stroke:

   _____
   _____
   _____
   _____

2. **Has anyone in your child's family had a heart attack?**
   a. ☐ No
   b. ☐ Yes

   How is the person related to your child (i.e. aunt, uncle, grandmother, etc. and on which side of the family, mothers or fathers) and at what age did they have their heart attack? Please list all relatives who have had a heart attack:

   _____
   _____
   _____
   _____

3. **Has anyone in your child's family had a blood clot in their arm, leg, or lung?**
   a. ☐ No
   b. ☐ Yes:

   How is the person related to your child (i.e. aunt, uncle, grandmother, etc. and on which side of the family, mothers or fathers) and at what age did they have their blood clot? Please list all relatives who have had a blood clot:

   _____
   _____
   _____
   _____

4. **Has anyone in your child's family had more than one miscarriage?**
   a. ☐ No
   b. ☐ Yes:

   How is the person related to your child (i.e. aunt, grandmother, etc. and on which side of the family, mothers or fathers) and how many miscarriages they have had? Please list all relatives who have had more than one miscarriage:

   _____
   _____
   _____
   _____

5. **Has anyone in your child's family had to take a blood thinner medication?**
   a. ☐ No
   b. ☐ Yes

   How is the person related to your child (i.e. aunt, uncle, grandmother, etc. and on which side of the family, mothers or fathers) and why they were on blood thinner medication (if you know)? Please list all relatives who have taken blood thinning medication:

   _____
   _____
   _____
   _____