# 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)** – functional test 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 (from PPAS)

| | | |
|---|---|---|
| Head midline | No ☐ | Yes ☐ |
| Trunk symmetrical | No ☐ | Yes ☐ |
| Pelvis neutral | No ☐ | Yes ☐ |
| Legs separated and straight relative to pelvis | 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 (from PPAS)**

| | | |
|---|---|---|
| Head midline | No □ | Yes □ |
| Trunk symmetrical | No □ | Yes □ |
| Pelvis neutral | No □ | Yes □ |
| Legs separated and straight relative to pelvis | No □ | Yes □ |
| Arms resting by side | 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 (from PPAS)**

| | | |
|---|---|---|
| Head midline | No ☐ | Yes ☐ |
| Trunk symmetrical | No ☐ | Yes ☐ |
| Pelvis neutral | No ☐ | Yes ☐ |
| Legs separated and straight relative to pelvis | No ☐ | Yes ☐ |
| Arms resting by side | 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 ☐

Does the person receive oral medication to reduce tone? 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