SCI Self Management – Primary Care Checklist
SUMMARY SHEET

(please give this sheet to your healthcare provider)

1. THINGS I WANT TO DISCUSS WITH MY HEALTH CARE PROVIDER

i. Issue/Problem: _____

_____

Details/description: _____

_____

_____

My Action Plan: _____

_____

_____

ii. Issue/Problem: _____

_____

Details/description: _____

_____

_____

My Action Plan: _____

_____

_____

iii. Issue/Problem: _____

_____

Details/description: _____

_____

_____

My Action Plan: _____

_____

_____

2. BLADDER

How do you empty your bladder?

- ❑ Clean intermittent self-catheterization (IC)
- ❑ Indwelling ("Foley") catheter
- ❑ Reflex voiding with external (condom) catheter
- ❑ Suprapubic catheter with:
  - ❑ Continuous drainage ❑ Intermittent drainage
- ❑ Spontaneous voiding with some voluntary control
- ❑ Other: _____

How often do you typically empty your bladder each day?

Times per day: _____

Overnight: _____

Has the way you empty your bladder changed in the last year?

❑ No ❑ Yes—Details: _____

How much fluid do you drink each day?

_____ litres (1 glass=250 ml)

List types of fluid (eg water, coffee/tea, alcohol): _____

_____

How many urinary tract infections (UTIs) have you had in the last year?

- ❑ 0
- ❑ 1-2
- ❑ 3-4
- ❑ 5 or more

Have you experienced any of the following symptoms recently?

- ❑ Difficulty passing catheters/bleeding
- ❑ Increased straining or time to pass urine
- ❑ Frequent catheter blockages
- ❑ Sediment or blood in urine
- ❑ Leakage, urgency or less warning before voiding
- ❑ Higher urine volume than usual
- ❑ Increased bladder spasms or lower abdominal discomfort
- ❑ Increased episodes of autonomic dysreflexia or spasticity

Have you had any surgical procedures affecting your urinary system (eg stone removal, bladder augmentation, sphincterotomy)?

_____

3. BOWEL

How do you empty your bowel?

(check all that apply)

- ❑ Spontaneous/voluntary evacuation
- ❑ Reflex stimulation with evacuation using:
  - ❑ Enema ❑ Suppository ❑ Digital stimulation
- ❑ Manual evacuation
- ❑ Other (eg colostomy, sacral root stimulation):

_____

How often do you empty your bowel?

- ❑ Daily
- ❑ Every second day
- ❑ Three times weekly
- ❑ Other: _____

When do you perform your bowel program?

- ❑ AM
- ❑ PM

On a typical day, how long does your bowel program take?

- ❑ Less than 15 mins.
- ❑ 15-30 mins.
- ❑ 30-45 mins.
- ❑ 45-60 mins.
- ❑ More than 1 hour

What is your stool consistency usually like?

- ❑ Smooth, well-formed
- ❑ Hard, small lumps
- ❑ Loose, poorly-formed, watery
- ❑ Both hard and soft segments
- ❑ Other: _____

Has your diet changed recently?

❑ No ❑ Yes

Details: _____

Has your bowel routine changed significantly in the past year?

❑ No ❑ Yes—Details: _____

3. BOWEL (Continued)

Has your weight changed significantly in the past year?

❑ No ❑ Yes—Details: _____

Is there a history of bowel disease in your family (eg inflammatory bowel disease, cancer)?

_____

Have you experienced any of the following recently?

- ❑ Constipation
- ❑ Bowel accidents/fecal incontinence
- ❑ Increased use of laxatives
- ❑ Sweating, headache or rash during bowel care
- ❑ Bleeding during or after bowel evacuation
- ❑ Rectal discomfort or mucus discharge after evacuation
- ❑ Abdominal bloating or cramping pain
- ❑ Nausea or vomiting
- ❑ Acid reflux/heartburn
- ❑ Other: _____

Do bowl problems ever prevent you from going out?

❑ No ❑ Yes—Details: _____

4. SKIN

Do you have any pressure areas/pressure sores right now?

Area	*When it occurred*	*Severity (Stage)*

4. SKIN (Continued)

Have you recently had any exams for a pressure sore (provide result if possible)?

- ❑ Blood tests: _____
- ❑ Wound swab: _____
- ❑ X-ray: _____
- ❑ Bone scan: _____
- ❑ Other: _____

Please describe how you are managing the most severe pressure sore that you currently have:

- ❑ Bedrest: _____
- ❑ Debridement/dressing: _____
- ❑ Antibiotics: _____
- ❑ Nutrition: _____
- ❑ Other: _____

Typically, how often do you inspect your skin?

- ❑ Twice daily
- ❑ Once daily
- ❑ Every second day
- ❑ Other: _____

How do you perform pressure relief?

- ❑ Lifting
- ❑ Weight shifting
- ❑ Reclining (in tilting wheelchair)
- ❑ Rolling/changes in positioning
- ❑ Transferring onto bed/recliner
- ❑ Other: _____

Typically, how often do you perform pressure relief?

- ❑ Every 15 minutes
- ❑ Every hour or so
- ❑ Other: _____

4. SKIN (Continued)

How do you transfer?

- ❑ Independent standing transfer
- ❑ Independent lift
- ❑ Independent with sliding board
- ❑ Standing transfer w/ assistance of one
- ❑ Sliding transfer w/ assistance
- ❑ Hoist/hoyer
- ❑ Other: _____

When was your last seating assessment? _____

Does any of your equipment need maintenance?
(eg bed, mattress, wheelchair, commode, shower chair, sling, hoist)

_____

_____

Have you had any skin problems other than pressure sores?

- ❑ Leg ulcers: _____
- ❑ Osteomyelitis (bone infection): _____
- ❑ Cellulitis (skin infection): _____
- ❑ Psoriasis: _____
- ❑ Fungal infections: _____
- ❑ Other: _____

Other issues/comments: _____
_____
_____
_____
_____
_____
_____

5a. UROGENITAL & SEXUAL HEALTH - MALE

Do any of the following interfere with your sexual function:

- ❑ Difficulty maintaining an erection
- ❑ Loss of ejaculation or trickling emission
- ❑ Altered sensation (painful or diminished)
- ❑ Autonomic dysreflexia
- ❑ Difficulty with positioning or incontinence
- ❑ Sad or anxious mood
- ❑ Other: _____

Do you use any of the following to facilitate sexual function (*check all that apply):*

- ❑ Oral medication (eg Viagra, Levitra or Cialis)
- ❑ Vacuum device with penile ring
- ❑ Intracavernosal injection
- ❑ Vibro-stimulator (eg FertiCare)
- ❑ Other: _____

What contraceptive method(s) do you use?

_____

Are you planning to have children?

❑ Yes ❑ No

Have you or your partner been unsuccessful in having children in the past?

❑ Yes ❑ No

Have you or your partner attended a fertility clinic or had fertility counseling?

❑ Yes ❑ No

Other issues/comments: _____
_____
_____
_____
_____

5b. UROGENITAL & SEXUAL HEALTH - FEMALE

Do any of the following interfere with your sexual function:

- ❑ Decreased lubrication
- ❑ Altered sensation (painful or diminished)
- ❑ Autonomic dysreflexia
- ❑ Difficulty with positioning or incontinence
- ❑ Sad or anxious mood
- ❑ Other: _____

Do you use any of the following to facilitate sexual function (*check all that apply):*

- ❑ Oral medication (eg Viagra)
- ❑ Assistive device (eg vibrator)
- ❑ Other: _____

What contraceptive method(s) do you use?

_____

Are you planning to have children?

❑ Yes ❑ No

Have you or your partner been unsuccessful in having children in the past?

❑ Yes ❑ No

Have you or your partner attended a fertility clinic or had an assistive procedure such as vibro/electroejaculation performed previously?

❑ Yes ❑ No

If you are aged 18-70, when was your last Pap smear?

_____

If you are aged 18-70, when was your last pelvic exam?

_____

Other issues/comments: _____

_____

_____

_____

_____

_____

6. CARDIOVASCULAR

Have you had any of the following symptoms in the past year?

- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath at rest or lying down
- ❑ Excessive shortness of breath with exertion
- ❑ Increased ankle/leg swelling
- ❑ Episodes of dizziness/feeling lightheaded
- ❑ Episodes of weakness/facial drop/slurred speech

Do you have any of the following risk factors?

- ❑ Smoking history
- ❑ Previous heart attack or stroke
- ❑ Family history of heart attacks or strokes
- ❑ Diabetes or family history of diabetes
- ❑ Obesity
- ❑ Symptoms: increased thirst, increased frequency of urination, changes in sensation

Do you do regular exercise? ❑ Yes ❑ No

Describe exercise program: _____

Have you recently experienced any of the following possible signs & symptoms of autonomic dysreflexia:

- ❑ Pounding headache
- ❑ Nasal stuffiness
- ❑ Flushing/blotching of skin above the injury level
- ❑ Blurred vision
- ❑ Heavy sweating above the injury level
- ❑ Shortness of breath
- ❑ Pale skin and/or goose bumps below the injury level
- ❑ Chills without fever
- ❑ Sense of apprehension or anxiety

What seemed to trigger these signs & symptoms?

Bladder:

- ❑ Distension (eg due to blocked catheter)
- ❑ Urinary tract infection
- ❑ Stones
- ❑ Procedures

6. CARDIOVASCULAR (Continued)

Bowel: ❑ Distension (eg due to blocked catheter)
❑ Rectal irritation (eg hemorrhoids)
Skin: ❑ Ingrown toenails
❑ Pressure sore
❑ Cellulitis (skin infection)
❑ Burns
Other: ❑ (eg fracture): _____

How often do you experience autonomic dysreflexia?
- ❑ Never
- ❑ Rarely
- ❑ Monthly
- ❑ Weekly
- ❑ Daily

Is it becoming more frequent or getting worse? ❑ Yes ❑ No

Do you have a plan for when autonomic dysreflexia occurs?
- ❑ Medication available to use in an emergency
- ❑ Wallet card
- ❑ Medicalert bracelet
- ❑ Other: _____

7. RESPIRATORY

Have you had any of the following symptoms in the past year?
- ❑ Increased frequency of respiratory infections
- ❑ Shortness of breath and/or tightness in chest
- ❑ Fatigue or decreased function due to shortness of breath
- ❑ Decreased ability to clear secretions (“wet cough”)
- ❑ Coughing up blood & recent weight loss
- ❑ New leg swelling

Are you currently experiencing any of the following symptoms?
- ❑ Excessive snoring or interrupted breathing at night
- ❑ Excessive sleepiness or tiredness during the day
- ❑ Waking with early morning headache
- ❑ Difficulty concentrating/learning new things

7. RESPIRATORY (Continued)

Have you had an influenza vaccine in the past year?
❑ Yes ❑ No
Have you ever had a pneumonia vaccine? ❑ Yes ❑ No
Have you ever had a sleep study? ❑ Yes ❑ No
If you have a CPAP or BIPAP machine, do you have any problems with your mask or machine? ❑ Yes ❑ No

8. NEURO

Have you had any concerns with your function, mobility or sensation declining or deteriorating over the past year?
_____

Have you had an MRI scan of your spine since you initial spinal cord injury?
❑ Yes ❑ No
If yes, why and when?_____

Have you been diagnosed with a syrinx/syringomyelia (a cyst in the spinal cord)?
❑ Yes ❑ No
If yes, have you seen a neurosurgeon?
❑ Yes ❑ No
Details (name of neurosurgeon, date last reviewed:
_____

Have you had increasing difficulty with any of the following activities?
- ❑ Transfers
- ❑ Wheelchair mobility
- ❑ Walking
- ❑ Bed mobility
- ❑ Performing stretches
- ❑ Transport/driving
- ❑ Employment
- ❑ Activities of daily living

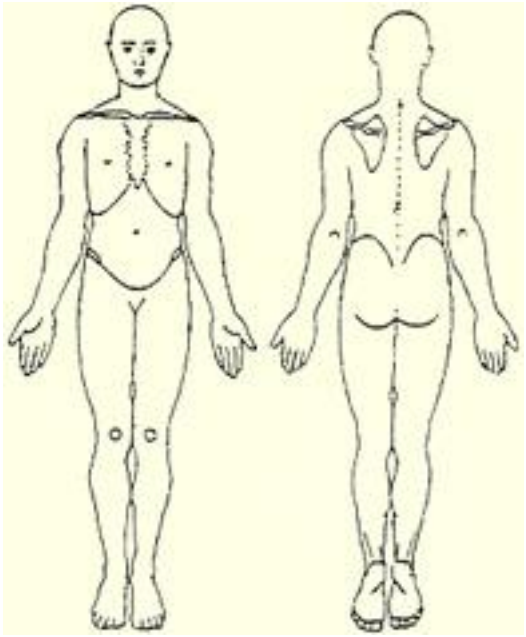
9. PAIN

Do you regularly experience any sort of pain? ❑ Yes ❑ No

If yes, have you recently experienced:

- ❑ No real change in the quality or severity of existing pain
- ❑ Worsening of existing pain
- ❑ Worsening of day-to-day function due to pain
- ❑ Onset of new pain

Please indicate on the body chart where you feel pain (*please shade in and label each location 1,2,3*):



Location 1

Describe how the pain feels in your own words:_____

_____

How frequent is it: _____

How severe is it (please circle appropriate number):

0 1 2 3 4 5 6 7 8 9 10

No pain *Worst pain imaginable*

9. PAIN (Continued)

Location 2

Describe how the pain feels in your own words:_____

_____

How frequent is it: _____

How severe is it (please circle appropriate number):

0 1 2 3 4 5 6 7 8 9 10

No pain *Worst pain imaginable*

Have you ever seen a health care provider for help with pain?

❑ Yes ❑ No

Details: _____

10. MUSCULOSKELETAL

Have you had any fractures (from falling, transfers, low impact accidents)? ❑ Yes ❑ No

Details: _____

Do you take medication (eg bisphosphonate) to improve your bone health? ❑ Yes ❑ No

Details: _____

Do you get 1500mg a day of Calcium (through diet and supplements)? ❑ Yes ❑ No

Details: _____

Do you take a Vitamin D supplement? ❑ Yes ❑ No

(How many?)_____

Have you noticed any significant change in your posture, increased curvature of the spine and/or difficulty in maintaining an upright position?

❑ Yes ❑ No

Details: _____

10. MUSCULOSKELETAL (Continued)

Do you experience muscle spasms or spasticity?
❑ Yes ❑ No

If yes, has it changed in the last 12 months? _____

Does it affect your function or independence?
❑ Yes ❑ No

Details: _____

11. GENERAL HEALTH

Does your daily diet include:
- ❑ 1 or more servings of meat/fish/chicken/eggs or legumes
- ❑ 2 or more servings of milk, cheese or yogurt
- ❑ 5 or more servings of fruit & vegetables

Do you have more than 4 (if male) or more than 2 (if female) servings of alcohol almost every day?
❑ Yes ❑ No

Do you use marijuana?
❑ Yes ❑ No

If you are female and over 50-69, when was your last mammogram?
_____

In the last 4 weeks, how often did you:	*Never/ a little*	*Some of the time*	*Most of the time*
-Feel tired or lacking in energy for no good reason	❑	❑	❑
-Feel depressed, hopeless or worthless	❑	❑	❑
-Feel that everything was an effort	❑	❑	❑
-Feel nervous, tense, worried or panicked	❑	❑	❑
-Have difficulty falling or staying asleep	❑	❑	❑

12. MY MEDICATIONS & SUPPLEMENTS

List all medications and supplements that you take:

NAME	WHY I TAKE IT	DOSE
Eg: Calcium supplement	Bone health	1000mg/ day

13. HEALTH MAINTENANCE – TESTS AND IMMUNIZATION

The following tests and vaccinations are recommended for people with SCI; suggested frequency is only a rough indication; for more specific information, ask your health care provider

DIAGNOSTIC TESTS		
Physical exam	Every year	❑
Blood pressure check	Every year	❑
Weight check	Every year	❑
Cholesterol check	At least every 5 years	❑
Bone-density test	Every 2 years	❑
Urodynamics	Every 2 years*	❑
Renal (kidney) ultrasound/IVP	Every 2 years*	❑
Cystoscopy	Ask your health care provider	
Blood sugar (glucose) test	Every 3 years after age 45	❑
Colorectal cancer test	After age 50**	❑
WOMEN:		❑
Mammogram	Every 1-2 years after age 40	❑
Breast exam	Every 3 years during 20s & 30s; every year after 40	❑
Pap test/pelvic exam	Every 1-2 years until age 29; every 2-3 years age 30-69	❑
MEN:		❑
Digital rectal exam	Ask your health care provider	❑
Prostate-specific antigen (PSA) test	Ask your health care provider	❑

*Every year during first 3 years post injury
**Frequency varies depending on risk factors & type of test

IMMUNIZATION		
Influenza (seasonal)	Every year	❑
Influenza (H1N1)	Once	❑
Pneumonia	Once (repeat after age 65)	❑
Diptheria/Tetanus	Every 10 years	❑

Sources:
Kailes, June Isaacson. Making Preventive Health Care Work for You – A Resource Guide for People with Physical Disabilities, 2006
Engel, Stella and Leong, Grace. Health Maintenance for Adults with Spinal Cord Injuries; Targeting Health Professionals, 2008

14. NOTES