

**STROKE SURVIVOR
COMMUNITY REINTEGRATION QUESTIONNAIRE**

This questionnaire is intended to help your doctors and nurses understand where you might benefit from more support in your home and community. If you need help to complete this questionnaire, please ask.

Name: _____

Date: _____

MY LIVING ARRANGEMENTS

I live in a: ☐ house

☐ apartment

☐ mobile home

☐ retirement home

☐ no fixed address

☐ other (please specify)

I live with: ☐ spouse/partner

☐ friends

☐ children

☐ parents

☐ other family members

☐ other residents & staff

☐ alone

☐ attendant care

Please check 'yes' or 'no' or N/A (not applicable) to each of the questions below.

	YES	NO	N/A
MY COMMUNITY SERVICES			
I have been referred to the community care access centre (CCAC).			
I am receiving:			
• Occupational Therapy			
• Physiotherapy			
• Speech Language			
• Social Work			
• Dietician			
• Nursing			
• Personal Support			
I am attending outpatient rehab or a rehab day hospital.			
I am receiving the following community support services?			
• Meals			
• Home Maintenance			
• Housekeeping			
• Other			
I am satisfied with the amount of assistance that I receive.			

HEALTH MANAGEMENT	YES	NO	N/A
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I am taking all the medicines that your doctor(s) has prescribed.			
I understand <u>why</u> I am taking all my prescription medications.			
I understand <u>how</u> to take all my prescription medications.			
All my questions about the medicines I'm taking have been answered.			
I have told my doctor about all the other drugs, vitamins or supplements that I am taking.			
I am sleeping well.			
I am eating well.			
My ability to chew and swallow is the same as before my stroke.			
My sexual drive/function is the same as before my stroke.			
My thinking is the same as before my stroke.			
My emotions are similar to before the stroke			
DAILY ROUTINES			
I am comfortable preparing my own meals.			
I am able to look after my personal needs – dressing, bathing/showering, brushing teeth, washing hair, nail care (hands and feet).			
I am able to toilet myself – getting to the bathroom on my own, using the toilet.			
I know about continence products (e.g. Depends™)			
I am comfortable caring for my children.			
I am able to manage my daily tasks around our home (e.g. washing dishes, doing laundry, vacuuming, dusting, yard work, snow removal)			
WORK/SCHOOL	YES	NO	N/A
I have returned to my previous work or			

school			
I feel able to return to work or school			
I have a plan to return to work			
I feel able to participate in retraining for a new job or other education			
I feel able to participate in volunteer activities			
I am able to concentrate well and participate in all activities at work or school			
I have enough energy for work or school			
MY SOCIAL NETWORK			
I am comfortable rejoining the groups and activities that I was involved in prior to my stroke			
I go out of the house about as often as I did before my stroke			
I have resumed my contacts with family and friends			
I have someone who gives me emotional support			
I am able to do the things I want to do			
MY HOME			
I am able to get around my home easily.			
I am using special equipment to move around our home. (e.g. walker, raised toilet seat, grab bars)			
My home has been adapted to help me with my mobility (e.g. wheelchair ramps, stair rails)			
I am always steady on my feet			
I receive help in and around my home from people who do not get paid to help me – friends, relatives, volunteers, family.			

MY COMMUNICATION	YES	NO	N/A
I feel able to communicate my needs and desires.			

I always understand what people are saying.			
I am satisfied with the way I communicate.			
I feel comfortable communicating in groups.			
I have aids to help me communicate – pictures, communication board, etc.			
MY COMMUNITY MOBILITY			
I have returned to driving.			
I am comfortable driving in my local area/short distances.			
I am comfortable driving long distances.			
I am comfortable driving at night.			
I would like to start driving again.			
I know where to go for a driving assessment so I can start to drive again.			
I am comfortable using transportation services (e.g. public transit, accessible transit, volunteer drivers).			
I am able to get to those places I need to – grocery shopping, banking, volunteer activities, rehabilitation, doctor's appointments, work.			
MY FINANCES			
I am comfortable managing my finances – banking, paying bills.			
i have enough money for my needs.			
I am receiving disability insurance/pension.			
I know how to get financial assistance – disability, pensions, disability tax credit, etc.			

MY PARTICIPATION IN RESEARCH	YES	NO	N/A
I am participating in a research study			
I would like to participate in a research study			

Is there anything else you would like to ask us? Is there anything else you would like us know?

Call 911 if you or someone you know experiences any of these warning signs of stroke:

SUDDEN loss of strength or sudden numbness in the face, arm or leg, even if temporary.

SUDDEN difficulty speaking or understanding or sudden confusion, even if temporary.

SUDDEN trouble with vision, even if temporary.

SUDDEN severe and unusual headache.

SUDDEN loss of balance, especially with any of the above signs.