**Post-Stroke Review**

**Self-Assessment Questionnaire**

**GM-SAT2: the Greater Manchester Stroke Assessment Tool- version 2©**

**Your Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

We would be grateful if you could complete the below questionnaire before your review. This will help us to tailor the review to focus of any problems or concerns that are important to you and help us to determine how best we can help you.

Please indicate your answer for each statement with a tick in a column (🗹)

| **I …** | Yes **and** I would like **additional** help and support | Yes **but** I have **enough** help and support | No |
| --- | --- | --- | --- |
| have new difficulties **managing my medicines**. This could include **access to medicines**. |  |  |  |
| would like to change my habits related to **smoking** and/or **alcohol**  |  |  |  |
| would like to change my habits related to **eating** and/or **exercise** |  |  |  |
| have recently **lost weight** without trying  |  |  |  |
| have recently **put on weight** without trying  |  |  |  |
| have new problems **swallowing** |  |  |  |
| have new problems with my **mouth or teeth** |  |  |  |
| have new problems with my **speech**, **reading** or **writing** |  |  |  |
| have new problems with my **sight** |  |  |  |
| have new problems with my **hearing** |  |  |  |
| have new **pain** that bothers me |  |  |  |
| have new issues caring for my **skin** |  |  |  |
| have new issues caring for my **feet**  |  |  |  |
| have new problems with **incontinence** |  |  |  |
| have problems **getting around inside** and/or **outside** |  |  |  |
| have recently **tripped** or **fallen** |  |  |  |
| feel **tired** all the time or get tired very quickly since my stroke |  |  |  |
| have new problems **sleeping** |  |  |  |
| have new problems **remembering** things or **concentrating** |  |  |  |
| have new problems with washing, getting dressed, cooking food, cleaning and other **daily activities** |  |  |  |
| do not have enough access to a **car** or **public transport** |  |  |  |
| have new difficulties with my **leisure activities** and/or **hobbies** |  |  |  |
| have new difficulties with my **work** |  |  |  |
| would like information about **benefits** or **money** |  |  |  |
| have new problems with **where I live** |  |  |  |
| have close **family or friends** who my need support |  |  |  |
| have worries about **sex** or **relationships** after my stroke |  |  |  |
| often feel **sad** or **depressed** |  |  |  |
| often feel **anxious** or **tense** |  |  |  |
| **laugh** or **cry** more since my stroke |  |  |  |

Have you recently had your cholesterol checked? 🞏 *No* 🞏 *Yes* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently had your blood pressure checked? 🞏 *No* 🞏 *Yes* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you would like to talk about at your review? *This could include reflections on your progress and recovery since your stroke.*









