

**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: \_\_\_\_\_

## DETAILED CHECKLIST

### 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: \_\_\_\_\_

DETAILED CHECKLIST

**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 bowel 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: \_\_\_\_\_

DETAILED CHECKLIST

**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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DETAILED CHECKLIST

**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

DETAILED CHECKLIST

**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

DETAILED CHECKLIST

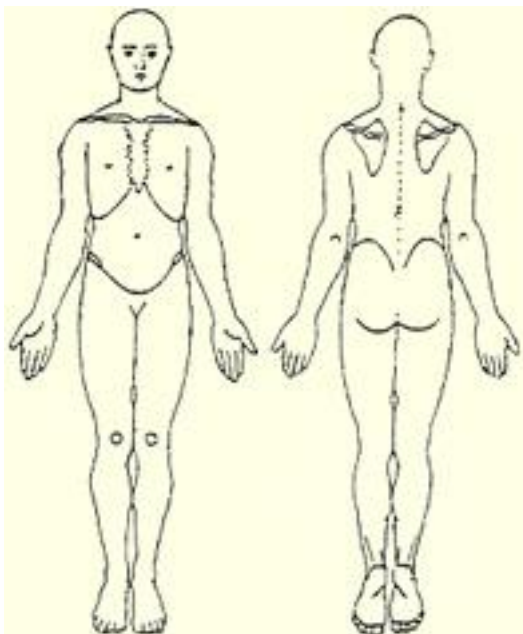
**9. PAIN**

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*):

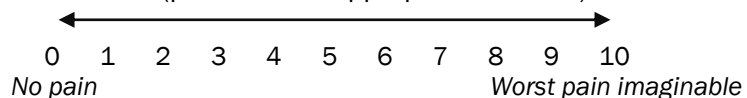


*Location 1*

Describe how the pain feels in your own words: \_\_\_\_\_

How frequent is it: \_\_\_\_\_

How severe is it (please circle appropriate number):



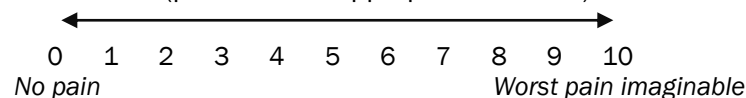
**9. PAIN (Continued)**

*Location 2*

Describe how the pain feels in your own words: \_\_\_\_\_

How frequent is it: \_\_\_\_\_

How severe is it (please circle appropriate number):



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: \_\_\_\_\_



