

# POST POLIO SUPPORT SOCIETY OF NZ: QUESTIONNAIRE

The Society is compiling a statistic outline of our membership to help with future planning and services that may be required by current and potential members. It is optional to answer *any* of the following questions but it would be very helpful to have your replies. Details that could identify individuals will remain confidential. As we gather statistics, a summary will be given from time to time in future editions of Polio News.

Mr/Miss/Mrs/Ms \_\_\_\_\_ Date \_\_\_\_\_  
 Given name \_\_\_\_\_ Surname \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Postcode \_\_\_\_\_  
 \_\_\_\_\_ Email address \_\_\_\_\_

If you are a member who did NOT contract polio please tick this box.

Then return this page to: PPSS NZ, P O Box 249, Oamaru 9444.

## PPSS NZ Questionnaire:

I consider myself to be: (tick)			
1. European - NZ Pakeha		2. European other (please specify)	
3. Maori		4. Pacific Island (please specify)	
		5. Other (please specify)	

1. PERSONAL POLIO DATA	
/ /	Date of birth
	Age now
	Age when you first had polio
	Year when you first had polio
	State or country where you first had polio
	Were you hospitalised when you first had polio?
	How long were you in hospital the first time approximately?
	Were you in an iron lung for breathing difficulties?
	Were you considered for an iron lung if you got worse?
	If not hospitalised, approximately how long were you kept at home?
	Was it months/years later when you were told it may be polio?

2. ABOUT YOUR POLIO ILLNESS (Tick for yes ✓)	
A	Did you have BULBAR POLIO (swallowing difficulties)?
B	Were you too SICK to remember much of your first weeks of polio?
C	Were you KEPT STILL for MONTHS as treatment for polio?
D	Were you IMMOBLISED for YEARS as treatment for polio?
E	Did you have "KENNY" (hot packs) treatment for polio?
F	Did you have regular PHYSIO as treatment after polio?
G	Did you have HYDROTHERAPY (warm bath/pool)?
H	Did you return for OUTPATIENT treatment for years?
I	Tick if you DID NOT HAVE any TREATMENT for polio?
J	Did others in your FAMILY also get polio?
K	Did you have SURGERY to stop your leg growing?
L	Did you have RADIATION to stop your leg growing?
M	Have you had POLIO-RELATED SURGERY to: (approximate date or age)
	1. Foot _____ 4. Hip _____ 7. Other _____
	2. Ankle _____ 5. Shoulder _____
	3. Knee _____ 6. Spine _____

### 3. PARTS OF YOUR BODY AFFECTED WHEN YOU HAD POLIO AND PRESENT PROBLEMS

(Tick✓)		When sickest		At best recovery		Problems now	
		No movement	Weak	No movement	Weak	No movement	Weak
1	Face						
2	Neck						
3	Right Arm						
4	Left Arm						
5	Breathing						
		Iron Lung other		Iron Lung other		Iron Lung other	
6	Abdomen						
7	Back						
8	Right Leg						
9	Left Leg						

### PRESENT HEALTH

Please feel free to add any comments. It all helps to find the answers.

#### 4. BODY CHART

Please fill in the chart below to indicate your present health. (Use these symbols to fill the whole area involved)



TOTAL PARALYSIS  
(no movement)



MUSCLE  
WEAKNESS



MUSCLE WASTAGE  
(thinner)



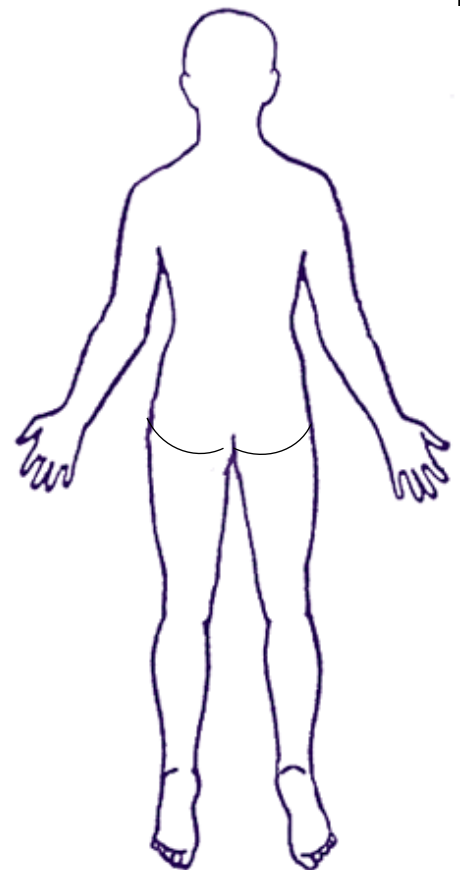
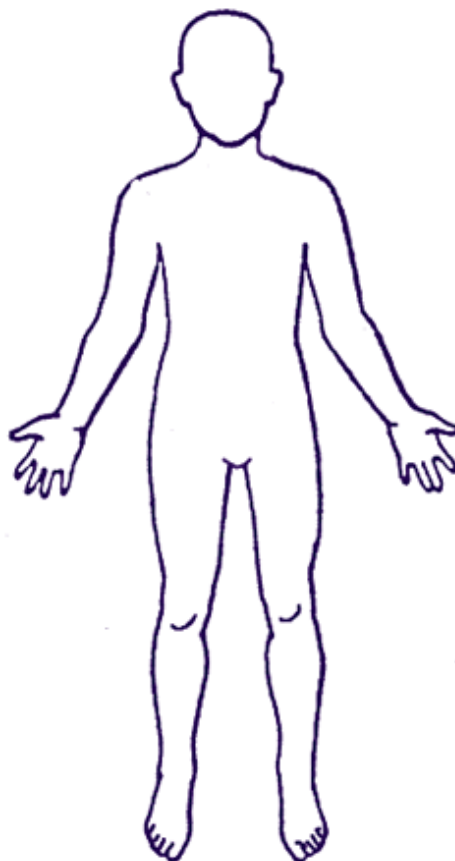
PAIN



FATIGUE

Front

Back



#### 5. PRESENT MOBILITY & AIDS

I now use etc (tick)

A	<input type="checkbox"/>	I can walk
B	<input type="checkbox"/>	Special shoes
C	<input type="checkbox"/>	In-shoe orthosis
D	<input type="checkbox"/>	Walking stick(s)
E	<input type="checkbox"/>	Walking frame
F	<input type="checkbox"/>	Crutches
G	<input type="checkbox"/>	Calliper(s) half
H	<input type="checkbox"/>	Callipers full
I	<input type="checkbox"/>	Knee brace/bandage
J	<input type="checkbox"/>	Corset (surgical)
K	<input type="checkbox"/>	Manual wheelchair
L	<input type="checkbox"/>	Electric wheelchair
M	<input type="checkbox"/>	Breathing help (day)
N	<input type="checkbox"/>	Breathing help (night)
O	<input type="checkbox"/>	Iron lung



Mild



Moderate



Severe



Fatigue all over body

**PRESENT HEALTH**

Do you now have any of these problems (not necessarily from polio)?

**6. RESPIRATORY AND SLEEPING (tick for yes)**

A	shortness of breath when doing normal activities e.g. bed making
B	shortness of breath when talking
C	asthma
D	hayfever
E	allergies -drug/ food
F	dermatitis/ psoriasis (circle which)
G	difficulty breathing through your nose/ either nostril
H	difficulty swallowing/ choking
I	wake short of breath
J	wake with a start for no obvious reason
K	snore
L	often have restless sleep
M	legs restless/ jumping at night
N	wake a lot during the night
O	nightmares of drowning/ suffocation
P	often wake with a headache in the morning
Q	wake even more tired in the morning

**7. PHYSICAL (tick for yes)**

A	permanent paralysis (little or no movement)
B	permanent weakness (for a long time)
C	increasing muscle weakness noticed over last few months/years
D	increasing muscle weakness noticed over last 5 -20 years
E	permanent muscle wastage (thinner, less muscle seen)
F	increasing muscle wastage (more or new last few years or so)
G	increase in size of (1) leg (2) ankle (3) foot (swelling)
H	muscle twitching /jumping / spasm
I	numbness or tingling
J	cramps
K	sweats
L	increasing difficulty climbing stairs
M	tire more quickly now when walking
N	falling/stumbling/ tripping over more
O	increasing tendency to drop things/difficulty using hands
P	increasing difficulty rising from chairs
Q	(1) painful joints (2) arthritis
R	sharp pain
S	nagging / aching pain
T	constant pain
U	back-ache
V	unusual chest pain that is not indigestion or heart
W	excessive tiredness or fatigue
X	urinary problems
Y	bowel or stomach problems

<b>DAILY LIVING (tick for yes)</b>	
A	Can you use public transport?
B	Do you have a car for transport?
C	Do you have hand controls to drive a car?
D	Do you have paid employment?
E	Do you have sheltered employment?
F	Do you have an invalid pension?
G	Do you have national superannuation? (old age pension)
H	Do you have other superannuation?
I	Are you a housewife (unpaid job)?
J	Due to health are you struggling to maintain your job?
K	Due to health are you struggling to maintain your gardening?
L	Due to health are you struggling to maintain your housework?
M	Due to health have you had to reduce or stop work?
N	Due to health have you had to reduce/adjust daily activities?
O	Do you have to/ feel you should take a rest during the day now?
P	Do you have home alterations/handrails/ramp etc
Q	Do you need home alterations?
R	Are your (1) shoes (2) calliper (3) brace etc not quite right?
S	Is lack of finance preventing your use of needed aids?
T	Is one leg/ arm shorter than the other?
U	Do you walk with a limp (1) all the time (2) only when tired?
V	Have you had a hip replacement?
W	Is one foot shorter than the other? If different, left shoe size                      right shoe size
X	Is your (1) wheelchair suitable (2) Cushioning comfortable supportive?
Y	How long have you used a wheel chair?                      years                      months
Z	How long have you needed help with breathing                      years                      months
	Would you like a support group in your area?

**On average your pain level is (ring one number only in the first column)**

Source: Carol Johnson <http://www.angelfire.com/ia/cjmachine/pain.html>

1	You experience very minor pain in parts of your body. You don't have to take any pain medications and you can do your work with no problems.
2	The minor pain has increased to dull aches in some parts of your body. You don't have to take medication and you still can work as usual but you don't want people 'in your face'!
3	Your minor pain is strong enough to get your attention. You resort to Over the Counter medications. You are getting grouchy now.
4	Now you can only ignore the pain if you are involved in activities at work or home. You are taking more Over the Counter medications but they don't last long. You begin to cut back on your activities in favor of just sitting down.
5	You can't ignore this pain for more than an hour, even with Over the Counter Medications. You cut back of all activities except the most important ones. Work is possible, just barely.
6	You simply cannot IGNORE your pain for even a few minutes. But with prescription pain medications you have limited functioning abilities.
7	This level of pain is the kind that keeps you awake at night, makes it hard to think and act. Your prescription medication only dulls the pain for a short time. You limit your activities in order of importance. You really can't work well.
8	This is serious pain. You don't want to do anything or be bothered by anyone. You have taken so much pain medication you are unable to fully concentrate on anything. Work is out of the question.
9	Very serious pain here. You cannot concentrate on anything but pain. You should not do business transactions or make any important decisions because of your limited mental state. You might want to give someone Power of Attorney. You cannot go to work and you shouldn't drive a car. At this point you begin withdrawing from the world around you.
10	Pain has made you totally unable to function. You don't want to deal with or talk to anyone. Even with narcotic pain medications you are still in horrible pain. You go to bed or go to the emergency room for any help you can get.

What is or was your OCCUPATION? \_\_\_\_\_

***Are you waiting for treatment or equipment? If so, please state what you have been waiting for and the length of time:***

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***How many people do you know who have had polio but are not members of our Society? Do you think that they might like an information pack?***

Number of people known to you, who have had polio, and are not members of our society:

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Please give details for those who would like an information pack (Remember to ask them first!)

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**ANY OTHER COMMENTS:** Please write here or attach another sheet.

Please fold this questionnaire into three, so that the return address is visible, sellotape it to seal the document, fix a stamp to it, and put it in the post..

Or post it in an envelope addressed to:

**Post Polio Support Society of NZ, P.O. Box 249 Oamaru 9444**

Post Polio Support Society of NZ,  
P.O. Box 249  
Oamaru 9444

Affix  
Stamp  
Here