

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

Patient's Name (Please print) _____ Patient's ID information _____

Examiner's Name _____

CURRENT MEDICATIONS AND TOTAL MG/DAY

Medication #1 _____ Total mg/Day _____ Medication #2 _____ Total mg/Day _____

INSTRUCTIONS: COMPLETE THE EXAMINATION PROCEDURE BEFORE ENTERING THESE RATINGS.

Facial and Oral Movements

1. Muscles of Facial Expression eg, movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing
2. Lips and Perioral Area eg, puckering, pouting, smacking
3. Jaw eg, biting, clenching, chewing, mouth opening, lateral movement
4. Tongue
Rate only increases in movement both in and out of mouth, NOT inability to sustain movement

None, normal Minimal (may be extreme normal) Mild Moderate Severe

<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Extremity Movements

5. Upper (arms, wrists, hands, fingers)
Include choreic movements (ie, rapid, objectively purposeless, irregular, spontaneous); athetoid movements (ie, slow, irregular, complex, serpentine). DO NOT include tremor (ie, repetitive, regular, rhythmic).
6. Lower (legs, knees, ankles, toes)
eg, lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot

<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

Trunk Movements

7. Neck, shoulders, hips
eg, rocking, twisting, squirming, pelvic gyrations

<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
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SCORING:

- Score the highest amplitude or frequency in a movement on the 0-4 scale, not the average;
- Score Activated Movements the same way; do not lower those numbers as was proposed at one time;
- A POSITIVE AIMS EXAMINATION IS A SCORE OF 2 IN TWO OR MORE MOVEMENTS or a SCORE OF 3 OR 4 IN A SINGLE MOVEMENT
- Do not sum the scores: e.g. a patient who has scores 1 in four movements DOES NOT have a positive AIMS score of 4.

Overall Severity

8. Severity of abnormal movements
9. Incapacitation due to abnormal movements

<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

10. Patient's awareness of abnormal movements (rate only patient's report)

	No awareness	Aware, no distress	Aware, mild distress	Aware, moderate distress	Aware, severe distress
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	

Dental Status

11. Current problems with teeth and/or dentures?
12. Does patient usually wear dentures?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Examiner's Signature _____ Next Exam Date _____