

San Mateo County Behavioral Health and Recovery Services
Abnormal Involuntary Movement Scale (AIMS)
To Determine Tardive Dyskinesia Symptoms
Attachment, BHRS Policy 90-07

- Observe the patient unobtrusively at rest (e.g., in waiting room).
- The chair used in this examination should be hard, firm and without arms.
- After observing the patient, rate on a scale of (0 none), 1 (minimal), 2 (mild), 3 (moderate), and 4 (severe) according to the severity of symptoms.
- Ask the patient whether there is anything in his/her mouth (i.e., gum, candy, etc.) and if there is, to remove it.
- Ask patient about the current condition of his/her teeth. Ask patient if he/she wears dentures. Ask patient “Do your teeth or dentures bother you now?”
- Ask patient whether he/she notices any movement in mouth, face, hands, or feet. If yes, ask to describe and to what extent they currently bother patient or interfere with his/her activities.

For the specific items

1. Have patient sit in chair with hands on knees, legs slightly apart and feet flat on floor. (Look at entire body for movements while in this position.)
2. Ask patient to sit with hands hanging unsupported. If male, between legs, if female and wearing a dress, hanging over knees. (Observe hands and other body areas.)
3. Ask patient to open mouth. (Observe tongue at rest within mouth.) Do this twice.
4. Ask patient to protrude tongue. (Observe abnormalities of tongue movement.) Do this twice.
5. Ask the patient to tap thumb with each finger, as rapidly as possible for 10 - 15 seconds, separately with right hand, then with left hand. (Observe facial and leg movements.)
6. Flex and extend patient’s left and right arms, one at a time.
7. Ask patient to stand up. (Observe in profile. Observe all body areas again, hips included.)
8. Ask patient to extend both arms outstretched in front with palms down. (Observe trunk, legs and mouth.)
9. Have patient walk a few paces, turn and walk back to chair. (Observe hands and gait.) Do this twice.

San Mateo County Behavioral Health and Recovery Services
ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

Complete for all clients at initial evaluation and before beginning any antipsychotics, lithium, or SSRIs. Repeat annually or more frequently if clinically indicated or if switching to a different antipsychotic or SSRI.

Patient's Name _____ MH# _____

Rated By _____ Date _____

Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously. (See instructions on reverse side.)

Code 0 = None 1 = Minimal, maybe extreme normal 2 = Mild 3 = Moderate
 4 = Severe (ratings for maximum movement during rating period)
 A = Movement only present during activation NR = Not Ratable

1. Muscles of facial expression (e.g., movements of forehead, eyebrows, or periorbital area; include frowning, blinking, smiling, grimacing)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
	A				NR
2. Lips and perioral regions (e.g., puckering, pouting, smacking, cheeks)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
	A				NR
3. Jaw (e.g., biting, clenching, chewing, mouth opening, lateral movement)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
	A				NR
4. Tongue Rate only movements both in and out of mouth, NOT inability to sustain movement.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
	A				NR
5. Upper extremities (arm, wrist, hand, fingers) Include choreic movements (i.e., rapid, objectively purposeless, irregular, spontaneous), athetoid movements (i.e., slow, irregular, complex serpentine) Do not include tremor (i.e., repetitive, regular, rhythmic)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
	A				NR
6. Lower extremities (legs, knees, ankles, toes) (e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion, and eversion of foot)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
	A				NR
7. Trunk (neck, shoulders, hips) (e.g., rocking, twisting, squirming, pelvic gyrations)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
	A				NR
Overall Severity of Abnormal Movements	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
Incapacitation by abnormal movements	A				NR
Patient awareness of abnormal movements	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
Rate only patient's report	A				NR
TOTAL T.D. - Like Score (total if items 1 through 7) =					
Dentures present? <input type="radio"/> Yes <input type="radio"/> No					
Current problem with teeth/dentures? <input type="radio"/> Yes <input type="radio"/> No					
If yes, what kind? _____					