

# **Abnormal Involuntary Movement Scale (AIMS)**

## Examination Procedure

Either before or after completing the examination procedure, observe the patient unobtrusively at rest (e.g., in the waiting room).

The chair to be used in this examination should be a hard, firm one without arms.

1. Ask the patient whether there is anything in his or her mouth (such as gum or candy) and, if so, to remove it.
2. Ask about the \*current\* condition of the patient's teeth. Ask if he or she wears dentures. Ask whether teeth or dentures bother the patient \*now\*.
3. Ask whether the patient notices any movements in his or her mouth, face, hands, or feet. If yes, ask the patient to describe them and to indicate to what extent they \*currently\* bother the patient or interfere with activities.
4. Have the patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at the entire body for movements while the patient is in this position.)
5. Ask the patient to sit with hands hanging unsupported -- if male, between his legs, if female and wearing a dress, hanging over her knees. (Observe hands and other body areas).
6. Ask the patient to open his or her mouth. (Observe the tongue at rest within the mouth.) Do this twice.
7. Ask the patient to protrude his or her tongue. (Observe abnormalities of tongue movement.) Do this twice.
8. Ask the patient to tap his or her thumb with each finger as rapidly as possible for 10 to 15 seconds, first with right hand, then with left hand. (Observe facial and leg movements.)
9. Flex and extend the patient's left and right arms, one at a time.
10. Ask the patient to stand up. (Observe the patient in profile. Observe all body areas again, hips included.)
11. Ask the patient to extend both arms out in front, palms down. (Observe trunk, legs, and mouth.)
12. Have the patient walk a few paces, turn, and walk back to the chair. (Observe hands and gait.) Do this twice.

Patient Information								
Patient		Date	Day	Mth.	Year	Time	Hour	Min
Personal notes								

## Scoring Procedure

Complete the examination procedure before making ratings.

For the movement ratings (the first three categories below), rate the highest severity observed.

0 = none, 1 = minimal (may be extreme normal), 2 = mild, 3 = moderate, 4 = severe.

According to the original AIMS instructions, one point is subtracted if movements are seen **only on activation**, but not all investigators follow that convention.

Facial and Oral Movements	
<p><b>1. Muscles of facial expression,</b> e.g., movements of forehead, eyebrows, periorbital area, cheeks. Include frowning, blinking, grimacing of upper face.</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
<p><b>2. Lips and perioral area,</b> e.g., puckering, pouting, smacking.</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
<p><b>3. Jaw,</b> e.g., biting, clenching, chewing, mouth opening, lateral movement.</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
<p><b>4. Tongue.</b> Rate only increase in movement both in and out of mouth, not inability to sustain movement.</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

<b>Extremity Movements</b>	
<p><b>5. Upper (arms, wrists, hands, fingers).</b></p> <p>Include movements that are choreic (rapid, objectively purposeless, irregular, spontaneous) or athetoid (slow, irregular, complex, serpentine). Do not include tremor (repetitive, regular, rhythmic movements).</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
<p><b>6. Lower (legs, knees, ankles, toes),</b></p> <p>e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
<b>Trunk Movements</b>	
<p><b>7. Neck, shoulders, hips,</b></p> <p>e.g., rocking, twisting, squirming, pelvic gyrations. Include diaphragmatic movements.</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
<b>Global Judgements</b>	
<p><b>8. Severity of abnormal movements.</b></p> <p>Based on the highest single score on the above items.</p>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
<p><b>9. Incapacitation due to abnormal movements.</b></p>	<input type="checkbox"/> none, normal <input type="checkbox"/> minimal <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
<p><b>10. Patient's awareness of abnormal movements.</b></p>	<input type="checkbox"/> no awareness <input type="checkbox"/> aware, no distress <input type="checkbox"/> aware, mild distress <input type="checkbox"/> aware, moderate distress <input type="checkbox"/> aware, severe distress

<b>Dental status</b>	
<b>11. Current problems with teeth and/or dentures.</b>	<input type="checkbox"/> no <input type="checkbox"/> yes
<b>12. Does patient usually wear dentures?</b>	<input type="checkbox"/> no <input type="checkbox"/> yes