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

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

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

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

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

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

Comments ________________________________________________________________________________________________________
Examiner’s Signature ___________________________________________________________ Next Exam Date_______________________