

SYMPTOM CHECKLIST

Name: _____ Date: _____

The following checklist will help other medical specialists, therapists or your hospital team optimize your care. This can serve as a summary of your problems or concerns, improving your team's understanding of you and your Parkinson's and helping them to tailor your treatment.

I have trouble in the following areas that may be affected by my treatment, hospital stay or procedure:

Motor

- Dyskinesia** – uncontrollable movements usually caused by medicine
- On-Off fluctuations** – periods of time when my medicines are working (*on*) that I can move better and when my medicines are not working (*off*) and I have difficulty moving. *Off* periods are usually end of dose. I MUST HAVE MY PARKINSON'S MEDICINES ON TIME TO REDUCE THIS PROBLEM.
- Dystonia** – involuntary muscle spasm, contraction leading to pain, flexion or twisting movements
- Balance problems**
- Freezing or gait or motor initiation problems (feet stuck to floor)**
- Swallowing problems**
- Communication and speech difficulties**

Non-motor

- Anxiety**
- Apathy or trouble self-initiating tasks**
- Bladder problems**
- Constipation**
- Depression**

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- Cognitive problems**
 - Memory problems or mild thinking difficulties
 - Dementia
 - Hallucinations or sensitivity to hallucinations with certain medicines
- Drooling**
- Fatigue**
- Impulsivity problems**
- Loss of smell or loss of appetite**
- Pain in these areas:** _____
- Sleep problems**
 - Trouble staying asleep
 - Restless legs syndrome
 - Sleep apnea
 - REM sleep behavior disorder: vivid, active, physical dreaming
 - Daytime sleepiness
- Sensations such as tingling, aches, pain, cold hands/feet**
- Sexual dysfunction**