

# **PARKINSON'S CARE QUESTIONNAIRE**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Healthcare Provider Name: \_\_\_\_\_

***What are your goals for this appointment?***

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***List your current or most bothersome problems or symptoms:***

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***Did you make the changes recommended during your last visit?***

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***Were your last treatment changes helpful? Explain:*** \_\_\_\_\_

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 **List any new medical problems or allergies since your last visit:** \_\_\_\_\_

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**Do you experience dyskinesia? (circle one) Yes / No**

**Do your medications wear “off” or stop working? (circle one) Yes / No**

**If yes, on average how long does each dose last? \_\_\_\_\_ hours**

**Have you had any falls since your last visit? (circle one) Yes / No**

**List any changes in your living arrangements:** \_\_\_\_\_

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**List prescription refills you need:** \_\_\_\_\_

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**Circle any problems that you had in the past month related to each specific area:**

**Movement**

Tremor

Stiffness

Slowness

Imbalance

Walking Problems

Frequent Falling

Movement Freezing

Involuntary Movements

Muscle Spasm/Cramping

Other (Explain): \_\_\_\_\_

**EVERY VICTORY COUNTS**

**Speech/Swallowing/Gastrointestinal**

Speech Changes	Swallowing Problems	Drooling
Pneumonia	Weight Loss	Weight Gain
Aspiration	Nausea	Vomiting
Abdominal Pain	Facial Masking	

Other (Explain): \_\_\_\_\_

**Bowel or Bladder/Autonomic/Other**

Bladder Problems	Constipation	Diarrhea
Chills/Sweats	Fatigue	Leg Swelling
Dizziness/Lightheadedness	Fainting or Loss of Consciousness	
Sexual Dysfunction		

Other (Explain): \_\_\_\_\_

**Cognitive/Behavioral**

Anxiety	Depression	Apathy
Sleep Problems	Daytime Sleepiness	Fatigue
Memory Loss	Confusion	Hallucinations
Paranoia	Delusions	Mania

Impulsive Spending, Sex or Gambling  
Executive Function Difficulties (planning, decision-making, etc.)  
Sudden, Uncontrolled Sleep “Attacks”

Other (Explain): \_\_\_\_\_

**Other**

Fever	Chills	Hearing Loss
Headache	Joint Pain	Back Pain
Neck Pain	Palpitations	Chest Pain
Cough	Hearing Loss	Vision Change
Numbness/Tingling	Driving Challenges	

**List any other concerns or problems that you have:** \_\_\_\_\_

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