

PARKINSON'S CARE QUESTIONNAIRE

Name: _____ Age: _____

Date of Birth: _____

Healthcare Provider Name: _____

What are your goals for this appointment?

List your current or most bothersome problems or symptoms:

Did you make the changes recommended during your last visit?

Were your last treatment changes helpful? Explain: _____





List any new medical problems or allergies since your last visit: _____

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: _____

List prescription refills you need: _____

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: _____
