

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 do make the changes recommended during your last visit?

(continued on back) →

Section 6: Clinical Appointments and Homework

6.13

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: _____

(continued on following page) →

Circle any problems that you had in the past month:

Movement

Tremor	Stiffness	Slowness
Imbalance	Walking Problems	Frequent Falling
Movement Freezing	Involuntary Movements	Muscle Spasm/Cramping

Speech/Swallowing/GI

Speech Changes	Swallowing Problems	Droping
Pneumonia	Weight Loss	Weight Gain
Nausea	Vomiting	Abdominal Pain

Bowel or Bladder/Autonomic/Other

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

Cognitive/Behavioral

Anxiety	Depression	Sleep Problems
Daytime Sleepiness	Vivid or Active Dreams	Memory Loss
Confusion	Hallucinations	Paranoia
Mania, Impulsive Spending, Sex or Gambling		
Sudden, Uncontrolled Sleep "Attacks"		

Other

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

List any other concerns or problems that you have here: _____