Parkinson's Summary

Complete this form, with a carepartner/family member's insight if possible, prior to your next neurologist visit. This form will help to optimize your medication and to suggest whether or not you may benefit from seeing other members of the healthcare team.

Name: _____

Date: _____

Place a checkmark in those boxes that apply to you
Please note: not all categories will necessarily apply to you now, or, perhaps at any point in your experience with Parkinson's Circle, and check, the ones that are major problems

I have had Parkinson's for _____ years

Medications

- ☐ I take my medication at the same time every day
- ☐ My medication runs out (wears off) before the next dose

The level of disability I experience with this wearing off is:

☐ None ☐ Mild ☐ Moderate ☐ Severe

- ☐ I have uncontrolled squirming movements (Dyskinesia)
- ☐ My muscles contract involuntarily, resulting in involuntary movements and/or pain (Dystonia)

☐ The level of disability I experience with this is:

☐ None ☐ Mild ☐ Moderate ☐ Severe

Motor Symptoms

- ☐ Tremors bother me

If yes: When: _____ Where: _____

- ☐ I feel stiff
- ☐ I am slow moving
- ☐ I have trouble starting movements
- ☐ I freeze (stop suddenly) when walking, or standing up
- ☐ I have problems with my balance

I fall: ☐ Rarely ☐ Once a month ☐ Once a week ☐ Daily

- ☐ I am afraid of falling
- ☐ My speech is hard to understand
- ☐ Drooling (dribbling of saliva during day time)
- ☐ I have difficulty swallowing
- ☐ I have difficulty with facial expressions, blinking, etc.

Non-Motor Symptoms

- ☐ I have sexual problems (my interest is too high/too low)
- ☐ I have bladder or bowel control difficulty (incontinence)
- ☐ I have a sudden sense of urgency to pass urine
- ☐ Pain is a problem
- ☐ I get light headed, dizzy or weak when standing up
- ☐ I suffer from fatigue/I find myself overly tired
- ☐ I have trouble sleeping at night
- ☐ I have nightmares
- ☐ I act out my dreams (i.e. thrash around while dreaming)
- ☐ I have numbness, tingling, or aching
- ☐ I socialize less than I used to
- ☐ My motivation is reduced (no get up and go)
- ☐ I have mood swings
- ☐ I feel depressed
- ☐ I feel anxious (frightened or panicky) at times
- ☐ I have a problem controlling gambling, eating, shopping and/or I spend too much time on a habit or hobby
- ☐ I see or hear things that I know or am told aren't there
- ☐ I am confused
- ☐ I have noticed changes in thinking, memory, planning etc.
- ☐ I can't smell things as well as I used to
- ☐ I am constipated

I have a bowel movement: ☐ Once or more a day ☐ every 2 days ☐ every 3 days ☐ less than every 3 days

- ☐ I have Diarrhea

Lifestyle

- ☐ I do cardiovascular fitness exercise at least 20 mins/day
- ☐ I drive a car
  - ☐ The Motor Vehicle Branch knows I have Parkinson's

I live:

- ☐ At home independently
- ☐ At home with help from friends/family
- ☐ At home with home care assistance
- ☐ In a personal care facility
- ☐ I don't have enough help at home
- ☐ My main caregiver is stressed

Over the past month, I would generally describe my activity as:

- ☐ Normal with no limitations
- ☐ Not my normal self, but able to be up and about with fairly normal activities
- ☐ Not feeling up to most things, but in bed or chair less than half the day
- ☐ Able to do little activity and spend most of the day in bed or chair
- ☐ Pretty much bedridden, rarely out of bed

Dietary Concerns

<u>Food Intake</u>

- ☐ Unchanged
- ☐ I am eating more than usual
- ☐ I am eating less than usual
- ☐ Meals seem to make my Parkinson's worse
- ☐ My weight has decreased in the last 2 weeks
- ☐ My weight has increased more than 5 pounds

Current weight: ___ 1 month ago: ___ 6 months ago: ___

<u>Dietary Symptoms</u> - The following problems have kept me from eating enough over the past 2 weeks:

- ☐ Difficulty swallowing or problems with choking
- ☐ Poor appetite
- ☐ I can't taste things as well as I used to
- ☐ Nausea (or feelings of sickness)
- ☐ Vomiting
- ☐ I have stomach bloating

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Société Parkinson du Centre et du Nord de l'Ontario
In Partnership with Parkinson Society Canada

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get it on time

Daily Diary of <u>the usual pattern</u> of control of motor symptoms:

Complete the following by checking one of the 4 choices for each of the hours of the day. This should be done in preparation for your next appointment.

This will help the neurologist adjust your medication timing. Also mark the time when you typically take your Parkinson medications.

1) "On with dyskinesia" = Excessive squirming movements are evident due to too much stimulation from meds (Not all patients experience these).
2) "On" = Mobility is close to normal as the medications are working well.
3) "Off" = Too slow, moving stiffly and / or slowly as the medications aren't working well at this time. Tremor if present will be worse.
4) Asleep

Time	5:00 AM	6:00	7:00	8:00	9:00	10:00	11:00	NOON	1:00	2:00	3:00	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	MID NIGHT	1:00	2:00	3:00	4:00
1) ON with DYSKINESIA																								
2) ON																								
3) OFF																								
4) ASLEEP																								
Medications Taken																								

MEDICATION	DOSAGE	TIME

My Main Problem Is:

Other Concerns:

Based on Parkinson Problem Profile by Dr. Hobson, Movement Disorder Specialist of Deer Lodge Centre Movement Disorder Clinic. Used with permission.