Parkinson's Foundation

Pre-visit Screening Short form

Date of visit: _____________

Patient name: _______________________

1. Please review the symptoms below and identity how bothersome each one is to you:

	Not at all	Somewhat	Quite a Bit	A Great Deal
Appetite/Weight loss				
Confusion				
Constipation				
Depression/Anxiety				
Hallucinations/delusions				
Pain				
Swallowing difficulty				
Tiredness/Drowsiness				
Urination				
OTHER:				
Do you struggle with the loss of **meaning** and **joy** in your life?				
Do you currently have what you would describe as **religious or spiritual struggles**?				

2. Please review the questions below and respond by checking Yes or No:

	Yes	No
1. Do you have an **advance directive** (living will, POLST/MOLST/MOST)?		
2. Do you have a **healthcare proxy/Medical Durable Power of Attorney**?		
3. Do you feel that you or **your family** would benefit from additional support?		

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