Questionnaire for People Living with Parkinson's Disease

How often <u>during the last month</u> have you had problems with the following? (Mark with an "X")

	Not at all	Sometimes	Often	Almost always
Memory, thinking: Following conversations, paying attention, thinking clearly, finding your way				
Hallucinations: Seeing, hearing, smelling, or feeling things that are not really there				
Depressed mood: Feeling low, sad, hopeless, or unable to enjoy things				
Anxiety: Feeling nervous, tense, unsettled				
Apathy: Feeling indifferent to doing activities or being with people				
Unusual or strong urges that are hard to control (such as gambling, shopping, eating, increased sex drive, hobbies, medications)				
Difficulty sleeping				
Daytime drowsiness or fatigue				
Urinary problems: Need to urinate urgently or too often, having accidents				
Moving bowels, constipation problems				
Lightheadedness or dizziness upon standing				
Talking or speech difficulties				

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	Not at all	Sometimes	Often	Almost always
Eating: Handling your food or using eating utensils				
Saliva: Excessive saliva or drooling				
Eating, swallowing, weight loss: including appetite changes, difficulties swallowing, handling utensils or feeding yourself				
Tremor or shaking				
Getting out of a bed, car or deep chair				
Walking and balance				
Freezing: Suddenly stopping or freezing as if your feet are stuck to the floor				
Falls				
Bothersome dyskinesias				
Using your hands for **dressing, hygiene, handwriting, typing** (from slowness to requiring assistance)				
Body discomfort such as pain, aches, cramps				
Doing hobbies and other things you enjoy				
Meaning and joy: Struggling with the loss of meaning or joy in your life				

Which of the problems you marked above are the top 1-3 you or your care partner would want to discuss today?

_____

_____

_____

Have you reviewed your advanced directive and health care proxy with your provider in the past year? (These are documents that put your wishes for future care in writing)

Yes _____ No _____

Is there a care partner who helps you with daily activities or managing your illness?

Yes _____ No _____

If yes, do they require any additional information, support or assistance?

Yes _____ No _____

Do you have additional questions about any of the following?

___ Your diagnosis

___ Medications

___ Referral to rehabilitation therapy (physical, occupational, speech, or recreational therapy)

___ Exercise and activity

___ Emotional and spiritual wellbeing

___ Care partner support

___ Roadmap for the future (advance care planning)

___ Getting involved in research

Please write any other issue not mentioned above that you would like to discuss today:

_____

Thank you

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