

RETURNING PATIENT FORM (for patients of Dr. Giroux)

DATE:	NAME:
REASON FOR VISIT:	

Rate the severity of each problem using a scale from 0 to 5 (circle one number) where
0 = No Problem or No Concern and 5 = Severe Problem or Biggest Concerns

							Doctor's Comments:
Writing	0	1	2	3	4	5	
Hand Movements	0	1	2	3	4	5	
Bathing, Dressing	0	1	2	3	4	5	
Walking	0	1	2	3	4	5	
Falls	0	1	2	3	4	5	
Freezing	0	1	2	3	4	5	
Dyskinesia / extra movements	0	1	2	3	4	5	
Muscle Spasm	0	1	2	3	4	5	
Medicine wearing off	0	1	2	3	4	5	
Speech	0	1	2	3	4	5	
Swallowing	0	1	2	3	4	5	
Sleep	0	1	2	3	4	5	
Depression	0	1	2	3	4	5	
Anxiety	0	1	2	3	4	5	
Motivation	0	1	2	3	4	5	
Thinking	0	1	2	3	4	5	
Hallucinations	0	1	2	3	4	5	
Pain	0	1	2	3	4	5	
Constipation	0	1	2	3	4	5	
Bladder	0	1	2	3	4	5	
Lightheadedness	0	1	2	3	4	5	
Sexual Function	0	1	2	3	4	5	

Check any problems you have had in the past month:

- | | | |
|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Breathing | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Skin changes |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vision change | |

Since your last visit:

- | | |
|--|--|
| Have you seen an physical therapist? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you seen an occupational therapist? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you seen a speech therapist? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

In the space below, note all medications, strength and the time of day you take them.

Medicine Name And Strength	A.M. (Morning)						P.M. (Afternoon/Evening)											A.M. (Night)						
	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5

Patient accompanied by and history also obtained from:
Allergies:
Change in Medical, Family or Social History since last visit:
Additional History:

Examination

BP/P sit:	BP/P stand:	RR:	General:
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Neurological

Hours since last dose medicine: _____ On or Off State: _____

UPDRS Motor		Right	Left	
Speech				Finger Tap
Facial Expression				Hand Grip
Resting tremor: Face				Pronate/Supinate
Resting Tremor Hands				Leg Agility
Resting Tremor Feet				Arise Chair
Action tremor				Posture
Rigidity Neck				Gait
Rigidity UE				Posture Stability
Rigidity LE				Bradykinesia

Impression and Plan

Diagnosis:

Motor:

Cognitive Behavioral:

Non-motor:

Functional:

Other:

Medical Complexity/Risk: _____

Follow up appointment: _____

Referral to: _____

Total time of visit (minutes) with greater than 50% in counseling: _____