



MOVEMENT DISORDERS NEW PATIENT INFORMATION

DATE:	NAME:	DATE OF BIRTH:
REFERRING DOCTOR:		HANDEDNESS: Right Left
HOW DID YOU HEAR ABOUT US? NWPf Your Physician Other (indicate)		

What symptoms are you experiencing? Check below:

Tremor	Chills/sweats/flushing	Constipation	Loss of consciousness
Worsened handwriting	Trouble getting to sleep	Weight loss	Seizure
Trouble dressing	Trouble staying asleep	Weight gain	Headache
Trouble getting out of a chair	Uncomfortable restlessness in legs	Feeling lightheaded when you stand up quickly	Joint pain
Trouble turning in bed	Daytime sleepiness	Urine control problems	Sore throat
Slow, shuffling walk	Vivid dreams	Bowel control problems	Sinus problems
Tripping over things	Hallucinations (seeing things that aren't there)	Sexual dysfunction	Cough
Poor balance	Trouble concentrating	Cold, purplish fingers/toes	Shortness of breath
Feet get stuck to the floor ("Freezing")	Memory loss	Swelling in feet/ankles	Chest pain
Medications take more than 30 minutes to kick in	Apathy (little interest in anything)	Talking or thrashing about in sleep	Heart palpitations
Medications wear off early	Depression	Snoring or gasping in sleep	Numbness or tingling
Dyskinesia	Anxiety	Frequent weeping (even when you aren't very sad)	Easy bruising
Weakness	Personality change	Falls (how often?)	Varicose veins
Foot cramps	Fatigue	Usually falls backwards	Heartburn
Muscle cramps	Nausea	Eyelids close involuntarily	Vision changes
Drooling	Vomiting	Swallowing problems	Hearing loss
Soft, hoarse voice	Abdominal pain	Poor appetite	Rash

What is your most bothersome symptom? _____

How did your symptoms first come on? How have they progressed?

List All Medical Diagnoses:

List Surgeries:

Name: _____

Date _____

This form allows us to identify those problems that bother you most and assess the effect of therapy on these problems. Please place a check mark in the appropriate square to indicate how often your movement disorder or Parkinson's disease has given you trouble in the following areas of your life **during the last month:**

	Never 0	Occasionally 1	Sometimes 2	Often 3	Always 4
MOBILITY					
Had difficulty doing the leisure activities you would like to do					
Had difficulty looking after your home (i.e., housework, cooking or yard work)					
Had difficulty carrying shopping bags					
Had problems walking half a mile					
Had problems walking 100 yards (approximately 1 block)					
Had problems getting around the house as easily as you would like					
Had difficulty getting around in public places					
Needed someone else to accompany you when you went out					
Felt frightened or worried about falling in public					
Been confined to the house more than you would like					
ACTIVITIES OF DAILY LIVING					
Had difficulty showering or bathing					
Had difficulty dressing					
Had difficulty with buttons or shoelaces					
Had problems writing clearly					
Had difficulty cutting up your food					
Had difficulty holding a drink without spilling it					
EMOTIONAL WELL-BEING					
Felt depressed					
Felt isolated and lonely					
Felt weepy or tearful					
Felt angry or bitter					
Felt anxious					
Felt worried about your future					
STIGMA					
Felt you had to hide your Parkinson's from people					
Avoided situations that involved eating or drinking in public					
Felt embarrassed in public					
Felt worried about others people's reaction to you					

(Continued)

	Never 0	Occasionally 1	Sometimes 2	Often 3	Always 4
SOCIAL SUPPORT					
Had problems with close personal relationships					
Received the support you needed from your spouse and partner					
Received the support you needed from family or close friends					
COGNITION					
Unexpectedly fallen asleep during day					
Had problems with concentration, i.e., when reading or watching TV					
Felt your memory was failing					
Had distressing dreams or hallucinations					
COMMUNICATION					
Had difficulty with speaking					
Felt unable to communicate effectively					
Felt ignored by people					
BODILY DISCOMFORT					
Had painful muscle cramps or spasms					
Had aches and pains in your joints or your body					
Felt uncomfortably hot or cold					

Prior to your first visit at the Parkinson's Care Center, who was treating your movement disorder or Parkinson's disease?

(Check one)?

Neurologist

Internist, Family Practitioner or Primary Care Doctor

FOR YOUR VISITS

Use this checklist to help you with your visits. Remember...these steps take work. However, they will help you gain the most you can out of your medical visits.

- Bring a notebook (3-ring binder works best) so that you can keep all information in one place.
- Take a patient questionnaire home with you after each visit. Fill it out in advance of appointment. Be complete. Do not use statements like “no changes”, “same as last visit”, or “the doctor knows what I am on.” Remember this is designed to reduce errors and help your doctor or clinician help you!
- Keep your own list of medications: include name, strength, timing, generic or trade. Also include prior medicines that were tried and not effective or caused side effects so that they are not used again.
- Keep a list of all your treating doctors to include name, address and FAX #.
- Keep a list of any changes that result from calls to your doctor between appointments.
- Keep track of medication refill needs before you run out.
- Keep a list of new medical problems, medicines, or new living arrangements.
- Finally, ask your doctor what information is important for you to bring to each visit

COMPREHENSIVE CARE FORM- PART 2

Please complete this section if your appointment is with Dr. Giroux

Please rate the severity of your symptoms on a scale from 0 to 5 with 5 being the most severe or most worrisome problem (circle one number for each problem)

0 = No problem or No Concern

5 = Severe problem or Biggest Concern

Writing	0	1	2	3	4	5
Fine 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

Are you interested in participating in clinical research trials?

Yes

No

Have you had blood work, brain MRI or CT scan?

Yes

No

Have you ever seen a physical therapist for your problem?

Yes

No

Have you ever seen a occupational therapist for your problem?

Yes

No

Have you ever seen a speech therapist for your problem?

Yes

No

HOME LAY OUT

Do you live: In my own home/apartment Assisted or Adult care home Nursing home
If you live at home, who lives at home with you? _____

If you live at home, check the appropriate: 1 story 2 or more stories requiring use of stairs

Bedroom on: 1st floor 2nd floor

Bathroom on: 1st floor 2nd floor

Do you use: Shower Tub

Do you have: Grab bars in bathroom Bedside commode Shower Chair Cane
 Walker Wheelchair Scooter Dressing or feeding equipment

DAILY ACTIVITIES/TASKS

In this section you will describe what you do at home, work and play.

Home:

Do you limit your activities due to falls or fear of falling? Yes No

Do your freeze or get stuck when moving? Yes No

How many falls per month? _____ per week? _____ per day? _____

Do you use a Walker Cane Wheelchair?

Do You Drive? Yes No

Check the tasks that you commonly do at home: Meal preparation Self Care
 Grocery shopping Housecleaning Yard work Child Care

Do you have help at home? Yes No

Please describe who helps and how often. _____

Work:

Are you currently Working Retired Disabled On medical leave

What is/was your occupation? _____

Check the tasks that you need to do at work: Desk Job Travel Physical labor

If you are working, how has your condition limited your ability to work?

Hobbies:

List your hobbies or interests: _____

Which hobbies are you no longer doing?

Exercise: Do you exercise now? If so, what and how much _____

Did you exercise before your symptoms began? If so what and how much _____

Disease and Self-management:

In this section, you will describe how active you are in your care.

Do you want to take a more active role in your health and medical care?

Yes No Not sure

Do you understand why you are taking medicines prescribed for you?

Yes No Not sure N/A

Do you know the most common side effects associated with your medicines for movement?

Yes No Not sure N/A

Do you prepare for your doctors visits? Yes No Not sure

Do you keep a notebook of problems and treatments related to your illness? Yes No

Do you have trouble taking your medicines as recommended? Yes No

Do you have trouble doing what is requested by your doctor or therapist?

Yes No Not sure N/A

Do you go to a support group? Yes No

Activities of Daily Living Scale

Please put a “**B**” by the percentage number below that describes your best and a “**W**” by the number that reflects your worst abilities during your day.

- 100%** Completely independent. Able to do all chores without slowness, difficulty or impairment. Essentially normal. Unaware of any difficulty.
- 90%** Completely independent. Able to do all chores with some degree of slowness, difficulty and impairment. Might take twice as long. Beginning to be aware of difficulty.
- 80%** Completely independent in most chores. Takes twice as long. Conscious of difficulty and slowness.
- 70%** Not completely independent. More difficulty with some chores. Three to four times as long in some. Must spend a large part of the day with chores.
- 60%** Some dependency. Can do most chores, exceedingly slow with much effort. Errors; some impossible.
- 50%** More dependent. Help with half of chores, slower, etc. Difficulty with everything.
- 40%** Very dependent. Can assist with all chores, but few alone.
- 30%** With effort, now and then does a few chores alone or begins alone. Much help needed.
- 20%** Nothing alone. Can be a slight help with some chores. Severe invalid.
- 10%** Totally dependent, helpless. Complete invalid.
- 0%** Vegetative functions such as swallowing, bladder and bowel functions are not functioning. Bed-ridden.