PARKINSON PREAPPOINTMENT PROBLEM PROFILE (2012) Name : _____ Date: _____

Complete this prior to your appointment, based on the previous week. Check the circle by the statements that apply to you.

I have had Parkinson's for _____ years

I live ◯ within Winnipeg...**or** ..◯ 30 minutes
◯ 1 hours ◯ 2 hours ◯ > 2 hours away
◯ I would prefer appointments by Tele-health

Accommodation

I live:
◯ at home independently
◯ at home with help from friends / family
◯ at home with home care assistance
◯ in a personal care facility

Activity and Function

Over the past week, my activity was:
◯ Normal with no limitations
◯ Not normal but capable of fairly normal activities
◯ Not up to most things, rest less than ½ the day
◯ I do little activity / spend most of day resting
◯ Pretty much bedridden, rarely out of bed

Exercise Regime

◯ I exercise 3 hours per week or more

Motor Symptoms / Medication Response

◯ I adjust my medication depending on how I feel
◯ Tremors bother me
◯ My hand coordination is poor
◯ I have difficulty getting out of low chairs
◯ My walking speed is too slow
◯ My medication benefit "runs out" (**wearing off)** prior to the next dose.
The level of disability I have with this wearing off is:
◯ None ◯ Mild ◯ Moderate ◯ Severe
◯ I have squirming, twisting movement - Dyskinesia
The level of disability I have due to dyskinesia is:
◯ None ◯ Mild ◯ Moderate ◯ Severe

Balance

◯ My balance isn't normal
◯ I am afraid of falling
◯ My feet seem to "freeze" to the ground
I fall: ◯ Rarely ◯ 1x /month ◯ 1x / week ◯ Daily

Sleep

◯ I have trouble falling asleep at night
◯ My legs are restless when I go to bed
◯ I have trouble rolling over in bed
◯ I have trouble staying asleep at night
◯ I need to get up to urinate
◯ I snore ◯ I have a CPAP machine
◯ I have nightmares
◯ I act out my dreams (thrash while dreaming)

Daytime Energy

◯ I suffer from fatigue
◯ I am extremely sleepy during the day
◯ I fall asleep suddenly, without warning

Autonomic Nervous System Symptoms

◯ I get light headed / dizzy on standing up
◯ I am constipated
◯ I have bladder control difficulty
◯ I have sexual problems
◯ My partner complains about my sexual interest being: ◯ too high / ◯ too low

Pain

◯ pain is a problem
Where?_____
◯ Pain worsens when my Parkinson's is bad.

Impulse Control Problems

◯ I spend too much time on a habit or hobby
◯ I have a problem with gambling
◯ I spend too much time on the computer

Mood

◯ I have mood swings
◯ I cry (feel weepy) more than I used to
◯ I am depressed
◯ I have thoughts of suicide

Social Interaction

◯ My motivation is reduced (no get up and go)
◯ I socialize less than I used to

Memory

◯ My memory is not normal
◯ I am confused
◯ I see / hear things that aren't real during the day (hallucinations)

Speech / Swallowing / Stomach Symptoms

◯ My speech is hard to understand
◯ Trouble swallowing, choking, cough with meals
◯ Drooling or dry mouth
◯ Poor appetite
◯ I can't taste things as well as I used to
◯ I can't smell things as well as I used to
◯ Nausea
◯ Vomiting
◯ Diarrhea
◯ I have stomach bloating

Food Intake

◯ Meals seem to make my Parkinson's worse
◯ My weight has changed in the last 6 months
◯ Unchanged ◯ Increased ◯ Decreased
Weight: ____ 1 mo. ago: ____ 6 mos. ago ____

Driving

◯ I drive a car
◯ I am uncertain if my driving is safe
◯ The Motor Vehicle Branch knows I have PD

Independence / Coping

◯ I don't have enough help at home
◯ My main caregiver is stressed
◯ I am stressed.

Life planning

◯ I have a will
◯ I have a health proxy
◯ I have chosen a power of attorney
◯ I have documented an "Advanced Care Plan / Directive" to outline my wishes regarding aggressiveness of future medical care
◯ I need help with life planning

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DAILY DIARY of THE USUAL PATTERN of motor symptoms:

Complete the following by checking one of the 4 choices for each of the hours of the day columns. This should be done the week prior to 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 or twisting movements (note – not the same as tremor and not all patients experience these).
2) "On" = Mobility is close to normal.
3) "Off" = Too slow, moving stiffly and / or slowly. Tremor if present will be worse. Muscle cramping may occur.
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	Midnight	1:00	2:00	3:00	4:00
1) On with Dyskinesia																								
2) On																								
3) Off																								
4) Asleep																								
Medication time																								

List **All** Current Medications including doses and times.

Medication Name	Dose	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Main Problem

_____

List other concerns

_____
_____
_____
_____
_____
_____
_____

I`d like to see the: ◯ Patient Coordinator / Resource Nurse ◯ Occupational Therapist (to assess / help how well I am managing my care at home)
◯ Physiotherapist ◯ Social Worker ◯ Speech or Swallowing Therapist ◯ Dietician / Nutritionist
◯ I`d like to learn more about the surgical treatment of Parkinson's Disease