

## Patient Parkinson's Symptoms Questionnaire

### Questions (Please circle a response)

#### Motor Symptoms:

- |  | Y | N             |
|--|---|---------------|
| • Do you experience tremor?<br>If so is it <b>Slightly,</b> <b>Mildly,</b> <b>Moderately,</b> <b>Or Severely</b> |   | Debilitating? |
| • Do you experience stiffness of muscles?  | Y | N             |
| • Do you have falls?   | Y | N             |
| • Do you experience freezing of gait?  | Y | N             |
| • Do you experience writhing, dance-like movements (dyskinesias)?  | Y | N             |
| • Do you experience difficulty swallowing?   | Y | N             |
| • Have you experienced changes in the volume or quality of your voice?   | Y | N             |
| • Do you have difficulty dressing yourself, feeding, or performing hygiene tasks because of your Parkinson?      | Y | N             |

#### Non-Motor Symptoms:

##### Mood/Behavioral

- |   |   |   |
|---|---|---|
| • Do you have symptoms of low mood or depression?   | Y | N |
| • Do you have symptoms of anxiety?  | Y | N |
| • Have you experienced symptoms of impulsivity, such as eating too much, doing repetitive activities, compulsive shopping, or take more medication than prescribed regularly? | Y | N |
| • Do you feel apathetic or disinterested in day-to-day activities, to the point where it interferes with your daily functioning?  | Y | N |

##### Sleep

- |   |   |   |
|---|---|---|
| • How many hours do you sleep per night?                              |   |   |
| • Do you have difficulty initiating and/or maintaining sleep?         | Y | N |
| • Do you act out your dreams (kicking, yelling, mimicking movements)? | Y | N |
| • Do you experience daytime sleepiness?                               | Y | N |
| • Do you have difficulty turning in bed?                              | Y | N |

##### Cognition

- |  |   |   |
|--|---|---|
| • Do you have difficulty remembering day-to-day tasks and/or details?                        | Y | N |
| • Do you have difficulty multi-tasking?  | Y | N |
| • Would you describe your attention span as <b>Good,</b> <b>Fair,</b> <b>Or Poor?</b>        |   |   |
| • Do you experience hallucinations, or see or hear people/animals/things that are not there? | Y | N |
| • Do you have difficulty turning in bed?   | Y | N |

##### Other Non-Motor Symptoms:

- |  |   |   |
|--|---|---|
| • Do you experience body pain?                                   | Y | N |
| • Do you experience urinary incontinence, frequency, or urgency? | Y | N |
| • Do you experience constipation?                                | Y | N |
| • Do you feel lightheaded when you stand too quickly?            | Y | N |

**PLEASE UNDERLINE THE TWO MOST BOTHERSOME SYMPTOMS IN THIS LIST**