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(Complete only for Tremor/Parkinson's)

Tremor/Parkinson's Clinical Symptoms Checklist Form
(Complete Both Sides Prior to Scheduled appointment Time)

Patient
Name _____ Date _____

Date of Birth _____

Current Tremor/Parkinson's Medications:

Name of Medication Strength Time of dose and # of tablets

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____
_____

Medication Side Effects (Yes/No) _____

Does your medication last from one dose to the next? (Yes/No)

Compulsive behaviors: (i.e. excessive spending, gambling, or hypersexual behaviors)? (Yes/No) _____

History of: Glaucoma (Yes/No)
Melanoma (Yes/No)

Other Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____

Additional Medications

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10._____

CONTINUE ON REVERSE SIDE

Patient Name _____ Date of Birth _____

Motor Symptoms

Tremor (Yes/No)	mild	moderate	severe
Rigidity (Yes/No)	mild	moderate	severe
Slowness (Yes/No)	mild	moderate	severe
Dyskinesia/Involuntary Movement (Yes/No)	mild	moderate	severe
Abnormal Hand/Foot/ Truncal Posturing (Yes/No)	mild	moderate	severe

Walking

Shuffling (Yes/No)	mild	moderate	severe
Start Hesitation (Yes/No)	mild	moderate	severe
Freezing (Yes/No)	mild	moderate	severe
Imbalance (Yes/No)	mild	moderate	severe

Use of assistive devices (Yes/No) _____

Any falls (Yes/No) _____

Activities of Daily Living/Dressing and Showering:

(Independent/Needs help) _____

Difficulty with Swallowing, Eating, or Drooling (Yes/No) _____

Associated Symptoms

Constipation/Diarrhea (Yes/No) _____

Urinary Symptoms (Yes/No) _____

Sexual Dysfunction (Yes/No) _____

Lightheadedness (orthostasis) (Yes/No) _____

Double Vision (Yes/No) _____

Depression (Yes/No) _____

Anxiety (Yes/No) _____

Sleep Disturbances (Yes/No) _____

Hallucinations (Yes/No) _____

Confusion (Yes/No) _____

Memory Loss (Yes/No) _____

Speech Difficulty (Yes/No) _____

Slowness in Processing Information (Yes/No) _____

Other symptoms? _____

_____