Olympia Neurology PLLC

Tremor, Movement Disorder and Parkinson's Questionnaire

Name:	
DOB:	**Today's Date:**
Who is completing form: **Patient Caregiver Other**	**Name of Caregiver (if applicable):**

1. Do you have tremors?	YES NO UNSURE
2. When did your tremors begin? (at what age)	
3. Which body part was affected first? (left arm, right foot, head)	(please describe)
4. Have other body parts become affected?	YES (please describe) NO
5. Does alcohol suppress your tremors?	YES NO UNSURE
6. Does caffeine make your tremors worse?	YES NO UNSURE
7. Does stress or anxiety make your tremors worse?	YES NO UNSURE
8. Have you had distressing dreams or hallucinations?	YES NO
9. Are there any other internal/environmental factors that have been noted to increase/decrease tremors?	YES (please describe) NO
10. Do any of your family members have a history of tremors? If yes, whom and at what age did tremors begin?	YES NO UNSURE
11. Were any medications started/increased or decreased around the time of onset of tremors?	YES NO UNSURE

12. Have you or those around you noted a tendency towards slowness of movement in recent months/years?	YES NO
13. Do you have significant stiffness or rigidity in muscles? If yes, where? When did this symptom begin?	YES NO
14. Do you have problems with balance or walking? Do you tend to shuffle? When did this symptom begin?	YES (Please describe) NO
15. Do you have impairment in your sense of smell?	YES NO
16. Do you have problems with constipation? If so, for how long?	YES NO
17. Do you have problems with anxiety/depression? If so, for how long? Have you been treated for anxiety or depression? If yes, what medications were prescribed?	YES NO
18. Do you have difficulties performing tasks that require fine motor control, such as buttoning clothing or manipulating small objects? If yes, which hand/hands are affected?	YES NO RIGHT LEFT BOTH
19. Have you (or others) noticed a decrease in the volume of your speech?	YES NO
20. Do you have difficulty swallowing? If yes, do you have greater difficulty with liquids or solids?	YES NO LIQUIDS SOLIDS BOTH
21. Do you notice a tendency towards excessive drooling or salivation?	YES NO
22. Have you been exposed to any unusual chemicals or heavy metals such as manganese?	YES NO UNSURE
23. Have you ever had a central nervous system (CNS) infection? (including meningitis and encephalitis) If yes please give dates/details	YES NO
24. Do you have a history of head trauma, concussion or loss of consciousness? If yes, please list dates and details.	YES NO

Treatment

Have you been treated with any medications to reduce your tremors or symptoms? YES NO

If yes, please circle medication and include details and dosage if known.

Medication	Dosage	Response or Side Effects
Sinemet (carbidopa/levodopa)		
Stalevo (carbidopa/levodopa/entacapone		
Comtan (entacapone)		
Parcopa (carbidopa/levodopa)		
Azilect (rasagiline)		
Selegiline		
Mirapex (pramipexole)		
Requip (ropinirole)		
Tasmar (tolcapone)		
Apokyn (apomorphine)		
Inderal (propranolol)		
Nadolol		
Primidone		
Topamax (topiramate)		
Neurontin (gabapentin)		
Klonopin (clonazepam)		
Others: Please list		

Activities of Daily Living (ADL)

Please circle the statement that best reflects your current level of independence.

100%- **Completely independent**: Able to do all activities without slowness, difficulty or impairment

90%- **Completely independent**: Able to do all activities with some slowness, difficulty or impairment. Activities may take twice as long to complete.

80%- **Independent in most activities**: Able to do most activities some may take twice as long. Consciousness of difficulty and slowing.

70%- **Not completely independent**: More difficulty with activities some taking three to four times as long to complete. May take large part of the day for chores.

(continued on next page)

60%- **Some dependency**: Can do most activities, but very slowly and with much effort, but some chores are impossible.

50%- **More dependent**: Help required with half of chores. Difficulty with everything.

40%- **Very dependent**: Can assist with all chores but manage few alone.

30%- **Dependent**: With effort, now and then does a few chores alone or begins alone. Much help is needed.

20%- **Dependent**: Cannot do anything alone. Can give some slight help with some chores. Severe invalid.

10%- **Totally Dependent**: Helpless

0%- **Vegetative**: Swallowing, bladder and bowel functions are not functioning. Bedridden.

Please read each question and circle the best answer that applies to you.

Part 1: Non-Motor Aspects of Experiences of Daily Living

1.7 Sleep Problems:

Over the past week have you had trouble going to sleep at night or staying asleep through the night? Consider how rested you felt after waking up in the morning.

0 = Normal- No problems.
1= Slight- Sleep problems are present but usually do not cause trouble getting a full night of sleep.
2= Mild- Sleep problems usually cause some difficulties getting a full night of sleep.
3= Moderate- Sleep problems cause a lot of difficulties getting a full night of sleep, but I still usually sleep for more than half the night.
4= Severe- I usually do not sleep for most of the night.

1.8 Daytime Sleepiness:

Over the past week, have you had any trouble staying awake during the daytime?

0 = Normal- No daytime sleepiness.
1= Slight- Daytime sleepiness occurs but I can resist and stay awake.
2= Mild- Sometimes I fall asleep when alone or relaxing. For example, while watching TV or reading.
3= Moderate- I sometimes fall asleep when I should not. For example, while eating or talking with other people.
4= Severe- I often fall asleep when I should not. For example, while eating or talking with other people.

1.9 Pain and Other Sensations:

Over the past week, have you had uncomfortable feelings in your body like pain, aches, tingling or cramps?

0 = Normal- No uncomfortable feelings.
1= Slight- I have these feelings. However, I can do things and be with other people without difficulty.
2= Mild- These feelings cause some problems when I do things or am with other people.
3= Moderate- These feelings cause a lot of problems, but they do not stop me from doing things or being with other people.
4= Severe- These feelings stop me from doing things or being with other people.

1.10 Urinary Problems

Over the past week, have you had trouble with urine control? For example, an urgent need to urinate, a need to urinate too often or urine accidents.

0 = Normal- No urine control problems.
1= Slight- I need to urinate often or urgently. However, these problems do not cause difficulties with my daily activities.
2= Mild- Urine problems cause some difficulties with my daily activities. However, I do not have urine accidents.
3= Moderate- Urine problems cause a lot of difficulties with my daily activities, including urine accidents.
4= Severe- I cannot control my urine and use a protective garment or have a bladder tube.

1.11 Constipation Problems

Over the past week, have you had constipation troubles that cause you difficulty moving your bowels?

0 = Normal- No constipation.
1= Slight- I have been constipated. I use extra effort to move my bowels. However, this problem does not disturb my activities or my being comfortable.
2= Mild- Constipation causes me to have some troubles doing things or being comfortable.
3= Moderate- Constipation causes me to have a lot of trouble doing things or being comfortable. However, it does not stop me from doing anything.
4= Severe- I usually need physical help from someone else to empty my bowels.

1.12 Light Headedness on Standing

Over the past week, have you felt faint, dizzy or foggy when you stand up after sitting or lying down?

0 = Normal- No dizzy or foggy feelings.
1= Slight- Dizzy or foggy feelings occur. However, they do not cause me troubles doing things.
2= Mild- Dizzy or foggy feelings cause me to hold on to something, but I do not need to sit or lie down.
3= Moderate- Dizzy or foggy feelings cause me to sit or lie down to avoid fainting or falling.
4= Severe- Dizzy or foggy feelings cause me to fall or faint.

1.13 Fatigue

Over the past week, have you usually felt fatigued? This feeling is NOT part of being sleepy or sad.

0 = Normal- No fatigue.
1= Slight- Fatigue occurs. However, it does not cause me troubles doing things or being with people.
2= Mild- Fatigue causes me some troubles doing things or being with people.
3= Moderate- Fatigue causes me a lot of troubles doing things or being with people. However, it does not stop me from doing anything.
4= Severe- Fatigue stops me from doing things or being with people.

Please read each question and circle the best answer that applies to you.

Part 2: Motor Aspects of Experiences of Daily Living

2.1 Speech

Over the past week, have you had problems with your speech?

0 = Normal- No not at all (no problems).
1= Slight- My speech is soft, slurred or uneven, but it does not cause others to ask me to repeat myself.
2= Mild- My speech causes people to ask me occasionally to repeat myself, but not everyday.
3= Moderate-My speech is unclear enough that others ask me to repeat myself every day even though
4= Severe- Most or all of my speech cannot be understood.

2.2 Saliva and Drooling

Over the past week, have you usually had too much saliva during when you're awake or when you sleep?

0 = Normal- Not at all (no problems)
1= Slight- I have too much saliva, but do not drool.
2= Mild- I have some drooling during sleep, but none when I am awake.
3= Moderate- I have some drooling when I am awake, but I usually do not need tissues or a handkerchief.
4= Severe- I have so much drooling that I regularly need to use tissues or a handkerchief to protect my clothes.

2.3 Chewing and Swallowing

Over the past week, have you usually had problems swallowing pills or eating meals? Do you need your pills cut or crushed or your meals to be made soft, chopped or blended to avoid choking?

0 = Normal- No problems.
1= Slight- I am aware of slowness in my chewing or increased effort at swallowing, but I do not choke or need to have my food specially prepared.
2= Mild- I need to have my pills curt or my food specially prepared because of chewing or swallowing problems, but I have not choked over the past week.
3= Moderate- I choked at least once in the past week.
4= Severe- Because of chewing and swallowing problems, I need a feeding tube.

2.4 Eating Tasks

Over the past week, have you usually had troubles handing your food and using eating utensils? For example, do you have trouble handling finger foods or using forks, knives, spoons or chopsticks?

0 = Normal- Not at all (no problems)
1= Slight- I am slow, but I do not need any help handling my food and have not had food spills while eating.
2= Mild- I am slow with my eating and have occasional food spills. I may need help with a few tasks such as cutting meat.
3= Moderate- I need help with many eating tasks but can manage some alone.
4= Severe- I need help for most or all eating tasks.

2.5 Dressing

Over the past week, have you usually had problems dressing? For Example, are you slow or do you need help with buttoning, using zippers, putting on or taking off your clothes or jewelry?

0 = Normal- Not at all (no problems)
1= Slight- I am slow but I do not need help.
2= Mild- I am slow and need help for a few dressing tasks (buttons, bracelets)
3= Moderate- I need help for many dressing tasks.
4= Severe- I need help for most or all dressing tasks.

2.6 Hygiene

Over the past week, have you usually been slow or do you need help with washing, bathing, shaving, brushing teeth, combing your hair or with other personal hygiene?

0 = Normal- Not at all (no problems)
1= Slight- I am slow but I do not need any help.
2= Mild- I need someone else to help me with some hygiene tasks.
3= Moderate- I need help for many hygiene tasks.
4= Severe- I need help for most or all of my hygiene tasks.

2.7 Handwriting

Over the past week, have people usually had trouble reading your handwriting?

0 = Normal- Not at all (no problems)
1= Slight- My writing is slow, clumsy or uneven, but all words are clear.
2= Mild- Some words are unclear and difficult to read.
3= Moderate- Many words are unclear and difficult to read.
4= Severe- Most or all words cannot be read.

2.8 Doing hobbies and other Activities

Over the past week, have you usually had trouble doing your hobbies or other things that you like to do?

0 = Normal- Not at all (no problems).
1= Slight- I am a bit slow but do these activities easily.
2= Mild- I have some difficulty doing these activities.
3= Moderate- I have major problems doing these activities, but still do most.
4= Severe- I am unable to do most or all of these activities.

2.9 Turning in Bed

Over the past week, do you usually have trouble turning over in bed?

0 = Normal- Not at all (no problems).
1= Slight- I have a bit of trouble turning, but I do not need any help.
2= Mild- I have a lot of trouble turning and need occasional help from someone else.
3= Moderate- To turn over I often need help from someone else.
4= Severe- I am unable to turn over without help from someone else.

2.10 Tremor
Over the past week, have you usually had shaking or tremor?

0 = Normal- Not at all. I have no shaking or tremor.
1= Slight- Shaking or tremor occurs but does not cause problems with any activity.
2= Mild- Shaking or tremor causes problems with only a few activities.
3= Moderate- Shaking or tremor causes problems with many of my daily activities.
4= Severe- Shaking or tremor causes problems with most or all activities.

2.11 Getting out of Bed, a Car or a Deep Chair
Over the past week, have you usually had trouble getting out of bed, a car or a deep chair?

0 = Normal- Not at all (no problems).
1= Slight- I am slow or awkward, but I usually can do it on my first try.
2= Mild- I need more than one try to get up or need occasional help.
3= Moderate- I sometimes need help to get up, but most times I can still do it on my own.
4= Severe- I need help most or all of the time.

2.12 Walking and Balance
Over the past week, have you usually had problems with balance and walking?

0 = Normal- Not at all (no problems).
1= Slight- I am slightly slow or may drag a leg. I never use a walking aid, but I do not need any help from another person.
2= Mild- I occasionally use a walking aid (cane, walker) but do not need any help from another person.
3= Moderate- I usually use a walking aid (cane, walker) to walk safely without falling. However, I do not usually need the support of another person.
4= Severe- I usually use the support of another person to walk safely without falling.

2.13 Freezing
Over the past week, on your usual day when walking, do you suddenly stop or freeze as if your feet are stuck to the floor?

0 = Normal- Not at all (no problems).
1= Slight- I briefly freeze but I can easily start walking again. I do not need help from someone else or a walking aid (cane or walker) because of freezing.
2= Mild- I freeze and have trouble starting to walk again, but I do not need someone's help or a walking aid because of freezing.
3= Moderate- When I freeze I have a lot of trouble starting to walk again, and because of freezing, I sometimes need to use a walking aid or someone else's help.
4= Severe- Because of freezing, most or all of the time, I need to use a walking aid or someone's help.