

## Checklist for People Living with Parkinson's Disease

Below is a list of health issues that people living with Parkinson's (PWP) may experience. It is important to note that not all people will experience all of these issues, and they may be due to causes other than PD. This list may help with self-management, conversations with your healthcare providers, or guide you to appropriate services. You can also use this checklist to track your symptoms over time. If the health issue relates to you, check the box if it is currently being managed or if it is a new issue. Check the last box if you need more information or services to address your health issue.

My Name: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Checklist for People Living with Parkinson's Disease			
<b>MEDICAL PLAN</b>			
I have a confirmed diagnosis (of Parkinson's disease or other Movement Disorders)	<input type="checkbox"/> yes	<input type="checkbox"/> no	
I have access to a Neurologist or doctor with a focus on Movement Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no	
I have appropriate medications for my Parkinson's disease symptoms	<input type="checkbox"/> yes	<input type="checkbox"/> no	
I know when/how to take my medications, such as timing or with certain foods	<input type="checkbox"/> yes	<input type="checkbox"/> no	
I have access to healthcare professionals (Social Worker, Physiotherapist, Occupational Therapist, Speech Language Pathologist, Nurse, Clinical Counsellor, Naturopath, Dietitian, Family Physician, Pharmacist)	<input type="checkbox"/> yes	<input type="checkbox"/> no	
<i>For the questions below, check the box if the health issue is new, is currently being managed or if you need more information.</i>	<b>New issue</b>	<b>Issue is being managed</b>	<b>Need more info</b>
<b>EVERYDAY ACTIVITIES</b>			
Dressing, washing, bathing, using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing food or meals (planning, shopping, or cooking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adapting to my home, leisure activities, or place of work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking my medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving a vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>MOVEMENT AND EXERCISE</b>			
Difficulty with moving around, stability, or balance (with or without a walking aid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
"Freezing" of movement or falling when walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting outside, accessing transit, or getting into/out of cars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercises and fall prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General weakness, such as difficulty turning over in bed or getting out of a chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical activity plan to achieve my 'daily dose' of exercise (prescription for exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>COMMUNICATION AND SWALLOWING</b>			
Communication challenges, such as voice, speech problems, and/or word-finding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing challenges, such as eating food or drinking; problems with drooling or choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss or changes in my ability to taste or smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>TREMOR, RIGIDITY, AND UNCONTROLLED MOVEMENTS</b>			
Rigidity, slowness, and stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyskinesia (uncontrolled fidgety movements caused by medications)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor or clumsy movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting postures (dystonia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PAIN</b>			
Pain and muscle/joint soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications, education, or strategies to help me live better with the pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	New issue	Issue is being managed	Need more info
<b>SLEEP AND RESTLESS LEG SYNDROME</b>			
Exhausted or fatigued, such as difficulty staying awake during daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty getting to sleep or staying asleep over night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having intense, vivid, or frightening dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talking or moving in my sleep, as if I was 'acting out' a dream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with restless legs at night (Restless Leg Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>AUTONOMIC SYMPTOMS (such as symptoms related to digestion and blood pressure)</b>			
Feeling light-headed, dizzy, or weak when I stand up (orthostatic hypotension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence and/or urgency (difficulty controlling my bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation (less than 3 bowel movements a week) or straining to pass a stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence or loss of orgasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive sweating or dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CHANGES IN MOOD AND MENTAL HEALTH</b>			
Feeling anxious, frightened, nervous, or tense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling sad, 'low', or 'blue'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing or hearing things that I know or am told are not there	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Believing things are happening to me that other people say are not	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest in what is happening around me or in doing things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CHANGES IN THINKING OR COGNITION</b>			
Poor memory, forgetfulness, or difficulty answering questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating or staying focused, including participating in conversations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>LIVING WITH PARKINSON'S DISEASE</b>			
Feeling less interested or more interested in sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finding it difficult to have sex when I try	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling socially isolated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Challenges with personal relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OTHER CHALLENGES</b>			
Managing gut health (with dietician, naturopath)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision or changes in vision not related to my prescription glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting or feelings of sickness (nausea)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained change in weight (not due to change in diet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of the legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing or labored breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of facial expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limbs tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What two main health issues you would like to focus on at this time:

1. \_\_\_\_\_
2. \_\_\_\_\_