OREGON HEALTH & SCIENCE UNIVERSITY

OHSU PARKINSON CENTER & MOVEMENT DISORDERS CLINIC
NEW AND RETURN PATIENTS

PATIENT LABEL
Name: _____
Birthdate: _____
Appt Date: _____

Patients

In order to make best use of time, please complete and give to your specialist.

In the last month, which symptoms are worse or impair quality of life.

Symptoms	PATIENT ➡	PRIORITIZE TOP 3 to DISCUSS TODAY with your specialist.	Care Partner's Observation
Tremor			
Slow movement			
Rigidity or stiffness			
Postural Instability (balance)	___(#)falls/near falls		
Freezing			
Dyskinesia (extra movements)			
Dystonia (painful cramps)			
Stooped posture			
Speech problems			
Swallowing problems			
Dizziness, lightheadedness			
Fatigue			
Sleep problems			
Sensory changes (vision, smell, temp)			
Abdominal discomfort, nausea			
Constipation / bowel issues			
Urinary frequency			
Sex/intimacy problems			
Anxiety			
Depression (mood)			
Memory changes, confusion			
Hallucinations, suspicious			
Other _____			

Medication list: Have you updated your medication list today? ☐ Yes ☐ No

Do you have any advance directive and/or POLST? ☐ Yes ☐ No
If yes, please provide us with a copy for your record.

Referral Request: I am interested in a referral to the following supportive therapies/services:
☐ Physical therapy ☐ Speech therapy ☐ Occupational therapy ☐ Counselor/psychologist
☐ Social Worker ☐ Nurse educator ☐ Home Health Services (PT, ST, OT in the home)

Education Request: I would like educational information about: _____

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FOR PATIENTS

ONCE PER YEAR, PLEASE COMPLETE THE CES-D (depression scale) BELOW.

CIRCLE the number which best describes how often you felt or behaved this way – **DURING THE PAST WEEK.**

	Rarely or None	Some or A Little (1-2 days)	Occasionally or Moderate (3-4 days)	Most or All (5+ days)
1. I was bothered by things that usually don't bother me	0	1	2	3
2. I did not feel like eating; my appetite was poor	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends	0	1	2	3
4. I felt that I was just as good as other people	0	1	2	3
5. I had trouble keeping my mind on what I was doing	0	1	2	3
6. I felt depressed	0	1	2	3
7. I felt that everything I did was an effort	0	1	2	3
8. I felt hopeful about the future	0	1	2	3
9. I thought my life had been a failure	0	1	2	3
10. I felt fearful	0	1	2	3
11. My sleep was restless	0	1	2	3
12. I was happy	0	1	2	3
13. I talked less than usual	0	1	2	3
14. I felt lonely	0	1	2	3
15. People were unfriendly	0	1	2	3
16. I enjoyed life	0	1	2	3
17. I had crying spells	0	1	2	3
18. I felt sad	0	1	2	3
19. I felt that people disliked me	0	1	2	3
20. I could not get "going"	0	1	2	3

FOR PARKINSON'S DISEASE (PD) CLIENTS ONLY

- Please take time to look at the bright green folder in your exam room: *OHSU Parkinson Center Research and Resources.*
- People with PD have been shown to be at greater risk for skin cancer (melanoma). We recommend that you have an annual exam by a dermatologist. Have you been seen by a dermatologist in the last 12 months? **Yes ☐** **No ☐**

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FOR CARE PARTNERS:

ONCE PER YEAR, PLEASE COMPLETE THE MCSI (Multidimensional Caregiver Strain Index) BELOW.

Caregiver Name: _____ Relationship to patient: _____

Circle the number which most closely reflects your feelings about caring for your partner, relative, or friend.	**Never**	**A little**	**Moder -ate**	**A lot**	**A great deal**
1. I feel I have less energy now that I am caring for my spouse or family member.	0	1	2	3	4
2. I feel physically strained because of caring for my spouse or family member.	0	1	2	3	4
3. I feel that my physical health has suffered because of caring for my spouse or family member.	0	1	2	3	4
4. I feel that my social life has suffered because of caring for my spouse or family member.	0	1	2	3	4
5. I have had to give up vacations or trips because of caring for my spouse or family member.	0	1	2	3	4
6. I am able to go out when I want.	0	1	2	3	4
7. I have had to make adjustments in my work or personal schedule.	0	1	2	3	4
8. Caring for/providing help for my spouse or family member is a financial strain.	0	1	2	3	4
9. I resent the extra cost of caring for my spouse or family member.	0	1	2	3	4
10. I have enough time to do the things I need to do (such as chores and helping).	0	1	2	3	4
11. I have a lot of time to myself.	0	1	2	3	4
12. I feel resentful toward my spouse or family member.	0	1	2	3	4
13. I feel angry toward my spouse or family member.	0	1	2	3	4
14. I feel pleased about my relationship with my spouse or family member.	0	1	2	3	4
15. My relationship with my spouse or family member is strained.	0	1	2	3	4
16. I am glad that I can provide care for my spouse or family member.	0	1	2	3	4
17. I feel that my spouse or family member tries to manipulate me.	0	1	2	3	4
18. I feel that my spouse or family member is overly demanding.	0	1	2	3	4

FAMILY CAREGIVER: Please indicate below any concerns you have about your **own** well-being.

_____

_____

☐ I am interested in speaking with a social worker.