



NEW PATIENT PACKET

NEW PATIENT QUESTIONNAIRE



1. Do you reside in a nursing home? YES NO

2. If so, what is the name of your nursing home? _____

3. Nursing home phone number: _____

4. Do you receive hospice care? YES NO

5. Do you receive home health and if so, name of company? YES NO

6. Are you in a skilled nursing facility, if so, what facility? YES NO

NEW PATIENT INFORMATION



Today's Date: _____

Name: _____ SSN: _____

Birthdate: _____ Gender: Male Female Marital Status: M S W D

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Race: (Please Check) American Indian or Alaska Native African American Asian

Native Hawaiian or Other Pacific Islander White Hispanic Other Prefer not to Disclose

Ethnicity: (Please Check One) Hispanic or Latino Not Hispanic or Latino Prefer not to Disclose

Name of Spouse: _____ Birthdate: _____

Occupation: _____ SSN: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Pharmacy & Phone Number: _____

How did you hear about our practice? _____

Would you like to register for our Patient Portal? YES NO Language: _____

Preferred method of contact: MOBILE HOME PORTAL

Signature of Patient or Legal Guardian _____ Date: _____

NEW PATIENT INFORMATION – CONT.



Complete this page if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birthdate: _____ SSN: _____

Occupation: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____

INSURANCE INFORMATION



Today's Date: _____

Patient's Name: _____

(PRIMARY INSURANCE)

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone: _____ Insured's Name: _____

Group Number: _____ Policy ID Number: _____

(SECONDARY INSURANCE)

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone: _____ Insured's Name: _____

Group Number: _____ Policy ID Number: _____

Did you sustain an injury at work?

YES NO

Are you covered under an employer or union policy?

YES NO

Is your spouse or other family member employed?

YES NO

Are you currently employed?

YES NO

Do you have a secondary insurance policy?

YES NO

Have you ever served in the military?

YES NO

Are you covered under any other health care plan?

YES NO

Are you enrolled in a Medicare Advantage Plan?

YES NO

Have you made any changes to your choice of Medicare options in the last open enrollment period?

YES NO

I am in a pre-existing provision with my insurance carrier.

YES NO

Who is responsible for this bill? _____

I have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature of Patient or Responsible Party: _____ Date: _____

PATIENT HISTORY QUESTIONNAIRE (PHQ)



Today's Date: _____ Name: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Please list all of your current doctors, conditions treated, and their phone numbers:

1. Physician: _____ Phone: _____ Fax: _____

Conditions Treated: _____

2. Physician: _____ Phone: _____ Fax: _____

Conditions Treated: _____

3. Physician: _____ Phone: _____ Fax: _____

Conditions Treated: _____

4. Physician: _____ Phone: _____ Fax: _____

Conditions Treated: _____

Past Medical History: Please check all that apply.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> aneurysm | <input type="checkbox"/> developmental problems | <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> anxiety disorder | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disease | <input type="checkbox"/> other sleep disorders |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> encephalitis | <input type="checkbox"/> liver disease | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> asthma | <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> lung disease | <input type="checkbox"/> Parkinsons disease |
| <input type="checkbox"/> autoimmune disease | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> lupus | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> back problems | <input type="checkbox"/> head trauma/injury | <input type="checkbox"/> MRSA | <input type="checkbox"/> sleep disorders |
| <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> headaches | <input type="checkbox"/> meniers | <input type="checkbox"/> spine problems |
| <input type="checkbox"/> brain tumors | <input type="checkbox"/> heart attack | <input type="checkbox"/> meningitis | <input type="checkbox"/> stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> heart disease | <input type="checkbox"/> mental problems | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> cancer | <input type="checkbox"/> heart problems | <input type="checkbox"/> migraines | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> hepatitis | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> congenital anomalies | <input type="checkbox"/> hospitalizations | <input type="checkbox"/> neck injury | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> hyperlipidemia | <input type="checkbox"/> neurological problems | <input type="checkbox"/> vision or eye problems |
| <input type="checkbox"/> dementia | <input type="checkbox"/> hypertension | <input type="checkbox"/> obstructive sleep apnea | |
| <input type="checkbox"/> depression | <input type="checkbox"/> hyper thyroidism | <input type="checkbox"/> orthopaedic problems | |

Please explain: _____

MEDICATION CHART



Please list all of your current medications below:

NAME OF MEDICATION & DOSAGE (MG)	WHAT TIME(S) DO YOU TAKE IT?	REASON FOR TAKING	MEDICATION START DATE & SIDE EFFECTS IF ANY
----------------------------------	------------------------------	-------------------	---

List any over the counter medications, vitamins, herbal supplements, or alternative therapies and the date you started taking them:

PATIENT SIGNATURE: _____

FAMILY AND SOCIAL HISTORY



Do you have any significant drug and/or allergic reactions? Please list them:

Please list any major surgeries and/or other hospitalizations and the dates they occurred:

Family History/ Please circle or fill in the blank:

Father: ALIVE DECEASED Age: _____

List any medical problems: _____

Mother: ALIVE DECEASED Age: _____

List any medical problems: _____

List any significant medical problems with other blood related family members such as uncles/aunts/brothers/sisters:

Social History/ Please check a single answer for each category or fill in the blank:

Do you have any pets? YES NO

Have you been exposed to chemicals or toxins? YES NO Details: _____

Have you been exposed to heavy metals? YES NO Details: _____

Diet: REGULAR VEGETARIAN VEGAN GLUTEN FREE SPECIFIC CARBOHYDRATE
 CARDIAC DIABETIC

Exercise level: NONE OCCASIONAL MODERATE HEAVY

How many days of moderate to strenuous exercise, like a brisk walk, did you do in teh last 7 days? _____

Able to care for self: YES NO

Blind or serious difficulty seeing: YES NO

Deaf or serious hearing difficulty: YES NO

Difficulty concentrating, remembering or making decisions: YES NO

Difficulty walking or climbing stairs: YES NO

Difficulty dressing or bathing: YES NO

Difficulty doing errands alone: YES NO

Hand dominance: LEFT RIGHT BILATERAL

Education: LESS THAN 8TH GRADE 8 9 10 11 12

2 YEAR COLLEGE 4 YEAR COLLEGE POST GRADUATE

Are you currently employed: _____

FAMILY AND SOCIAL HISTORY – CONT.



Smoking status: NEVER SMOKER FORMER SMOKER CURRENT EVERY DAY SMOKER
 CURRENT SOME DAY SMOKER UNKNOWN IF EVER SMOKED
 SMOKER - CURRENT STATUS UNKNOWN UNKNOWN IF EVER SMOKED
 NOT TOLERATED PATIENT REFUSED NOT INDICATED

How many years have you smoked tobacco? : _____

Do you or have you ever used any other forms of tabacco or nicotine? YES NO

Do you or have you ever used e-cigarettes or vape? NEVER USED ELECTRONIC CIGARETTES
 FORMER USER OF ELECTRONIC CIGARETTES CURRENT USER OF ELECTRONIC CIGARETTES

What was the date of your most recent tobacco screening? _____

What is your level of alcohol consumption? NONE OCCASIONAL MODERATE HEAVY

Do you use an illicit or recreational drugs? YES NO If yes, please list the illicit drug used: _____

What is your level of caffine intake? NONE OCCASIONAL MODERATE HEAVY

What is your relationship status? UNKNOWN MARRIED SINGLE DIVORCED SEPARATED
 WIDOWED DOMESTIC PARTNER OTHER

Family history of heart disease: YES NO

Have you been to an area known to be high risk for COVID-19? YES NO

In the 14 days before symptom onset, have you had close contact with a laboratory-confirmed COVID-19 while that person was ill? YES NO NOTES: _____

In the 14 days before symptom onset, have you had close contact with a person who is under investigation for COVID-19 while that person was ill? YES NO NOTES: _____

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night?

NOT AT ALL ONLY A LITTLE TO SOME EXTENT RATHER MUCH VERY MUCH

Gender Identity: IDENTIFIES AS MALE IDENTIFIES AS FEMALE TRANSGENDER MALE/FEMALE-TO-MALE (FTM) TRANSGENDER FEMALE/MALE-TO-FEMALE (MTF) GENDER NON-CONFORMING (NEITHER EXCLUSIVELY MALE OR FEMALE) ADDITIONAL GENDER CATEGORY/OTHER PLEASE SPECIFY _____
 REFUSES TO DISCLOSE

Assigned Sex at Birth: MALE FEMALE CHOOSE NOT TO DISCLOSE UNKNOWN

Pronouns: HE/HIM SHE/HER THEY/THEM

First Name Used: _____

Secual Orientation: LESBIAN, GAY OR HOMOSEXUAL STRAIGHT OR HETEROSEXUAL BISEXUAL
 SOMETHING ELSE/PLEASE DESCRIBE _____ DON'D KNOW
 CHOOSE NOT TO DISCLOSE

Medical power of attorney: YES NO If yes, list your MPOA: _____

Accident related injury: YES NO



REVIEW OF SYSTEMS

Please update on each visit.
Check all that apply.

Today's Date: _____ Name: _____

CONSTITUTIONAL

- fever
- night sweats
- weight gain
- weight loss
- exercise intolerance
- sedation
- lethargy

EYES

- dry eyes
- irritation
- vision change

ENMT

Ears:

- difficulty hearing
- ear pain

Nose:

- frequent nosebleeds
- nose problems
- sinus problems
- decreased or absent sense of smell

Mouth/Throat:

- bleeding gums
- dry mouth
- snoring
- oral abnormalities
- vocal tremor
- hoarseness
- weak voice
- choking
- sore throat
- mouth ulcer
- teeth abnormalities
- mouth breathing

CARDIOVASCULAR

- chest pain on exertion
- arm pain on exertion
- shortness of breath when walking

- shortness of breath when lying down
- palpitations
- known heart murmur
- lightheadedness
- swelling in the extremities
- neck pain

RESPIRATORY

- cough
- wheezing
- shortness of breath
- coughing up blood
- sleep apnea

GASTROINTESTINAL

- abdominal pain
- nausea
- vomiting
- constipation
- change in appetite
- black or tarry stools
- frequent diarrhea
- vomiting blood
- indigestion
- GERD

GENITOURINARY

- urinary loss of control
- difficulty urinating
- increased urinary frequency
- blood in urine
- incomplete emptying
- vaginal dryness
- unexplained vaginal bleeding
- erectile dysfunction (ED)
- lack of morning erections

MUSCULOSKELETAL

- muscle aches
- muscle weakness
- joint pain
- back pain

INTEGUMENTARY

- abnormal mole
- growth or ulcer
- jaundice
- rash
- laceration

NEUROLOGIC

- weakness or paralysis
- numbness or tingling
- seizures
- dizziness or spinning sensation
- frequent or severe headaches
- restless legs
- tremor
- bladder symptoms
- bowel symptoms
- confusion
- memory loss
- speech disorder
- blackouts
- muscle twitching
- cramps
- headaches
- vertigo
- dizziness
- fininitus
- blurred vision
- visual loss
- double vision
- difficulty with gait or walking

PSYCHIATRIC

- depression
- sleep disturbances
- alcohol abuse
- anxiety

- hallucinations
- suicidal thoughts
- restless sleep
- feeling unsafe in a relationship

ENDOCRINE

- fatigue
- hair loss
- increased hair growth
- cold intolerance
- increased thirst
- decreased sexual interest (libido)

HEMATOLOGIC/LYMPHATIC

- swollen glands
- easy bruising
- excessive bleeding

ALLERGIC/IMMUNOLOGIC

- runny nose
- itching
- frequent sneezing
- asthma

BP: _____ / _____

HR: _____

Weight: _____

Temp.: _____

If you have no symptoms to report for today's visit please initial and date below:



NEW PATIENT VISITS

Welcome to Neurology Solutions Consultants, a Movement Disorders Center.

As a New Patient, you will be scheduled as soon as we receive your completed new patient packet. At NSC we believe in a TEAM approach, so you may be seen by the doctor, advanced practice provider (APP), doctor of physical therapy (DPT) or medical assistant.

We are pleased to have you as a New Patient and we will try our best to manage your symptoms as effectively as possible. We believe that our TEAM approach is a great asset to managing your continued care.

Thank you for your cooperation.

NSC APPOINTMENT GUIDELINE

1. Please arrive 10-15 minutes before your appointment time. **Patients that arrive past their appointment time may need to reschedule their appointment.** Accidentally missed appointments will result in a charge of \$35 to your account if not excused by contacting the office at least 24 hours in advance.
2. Copays will be collected at the time of the appointment.
3. Subsequent follow-ups, cognitive, motor and physical therapy appointments may last 45-60 minutes. Additional follow-ups will be offered until the diagnosis and management plan are fully understood.
4. Chart review, dictation and/or documentation may occur during the visit.
5. Patients may be video recorded to capture their neurological status as part of the visit. These recordings may be shown to other medical professionals for diagnostic or educational purposes.
6. In order to limit the risk of emergencies on the weekends, **please do not start any medication changes on Thursday, Friday, Saturday or Sunday.**

CONSENTS (PAGE 2 OF 5) ADVANCED PRACTICE PROVIDER



This office has on staff an advance practice provider (APP) to assist in the delivery of medical care. An APP is not a doctor. An APP is a registered nurse who has received advanced education and training in the provision of health care. An APP can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. Our APP has trained with Dr. Izor to help him treat our patients.

I have read the above, and hereby consent to the services of an APP for my health care needs. I understand that at any time I can refuse to see the APP and request to see a physician.

CONSENT TO TREAT

I, _____, or my legal guardian/parent authorize Robert Izor, M.D., to provide medical care reasonable by today's standards.

OFFICE PAYMENT POLICY

Effective September 1, 2007, our office policy regarding outstanding account balances is as follows: Before being seen in the office again, you must pay 25% of your outstanding balance and set up a reasonable payment plan for the remaining balance. We will schedule a monthly payment of the same amount that will be due by the same date each month, until paid in full.

If you have Medicare with no secondary insurance, you will be responsible at the time of service to pay the 20% co-insurance.

All patients including pump patients must keep up the scheduled monthly payments or we will not be able to see you in the office. We will have no choice but to refer you to the hospital emergency room.

ASSIGNMENT OF BENEFITS

I, _____, understand that services rendered to me by Neurology Solutions Movement Disorders Center are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Neurology Solutions Movement Disorders Center and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the



CONSENTS (PAGE 3 OF 5)

prompt payment of the claim by the insurance company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Neurology Solutions Movement Disorders Center within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event that I receive any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to Neurology Solutions Movement Disorders Center immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Neurology Solutions Movement Disorders Center to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dear PATIENT,

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Thank you for your cooperation.



E-Prescribing

E-PRESCRIBING is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. It has been determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Neurology Solutions Consultants can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

PHONE CONTACT CONSENT AND AUTHORIZATION

I, _____, with respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, for the below listed individual, fully consent to and authorize [ProviderProfileFullName] ("Healthcare Provider") or any of its automated systems to contact me via phone (including to my cellular phone by way of phone call or text message) in relation to any services received from Healthcare Provider or any services planned to be received from Healthcare Provider (including any billing items or appointment reminders).

HIPAA

Rule of Patient Authorization Agreement:

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§ 164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals. I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.



I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement:

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§ 164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- That this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer at 512-977-7000, x109. I have read and understand the above Notice of Privacy Practices.

Signature of Patient or Legal Representative Witness: _____

Printed Patient Name: _____

Date Signed: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION



I authorize the named health care provider to release the information or records specified to Neurology Solutions Consultants upon request in person or by mail to the address specified at the time of the request.

Physician or Facility releasing records (Name and Address):

Patient:
SS#
DOB:

RECORDS AUTHORIZED TO BE RELEASED (Please check records to be released.)

- Admission history and physical
- Discharge summary
- Complete hospital chart
- Office notes
- Outpatient records
- Psychiatric and other mental health records
- Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
- Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me (These records should be redacted to protect information pertaining to other patients.)
- Other (specify):
- Lab reports
- Radiological images
- Consultation notes or reports
- Complaints or grievances filed, with responses or dispositions

Extent or nature of records to be released:

This information will be used for the purpose of (choose one option below):

- Providing advocacy service
- coordination of care
- Other activities at the request of the individual
- Continuing Care

I ALSO UNDERSTAND THAT:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Neurology Solutions Consultants, P.A. may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient or Representative Signature

Date

Name of Representative

Relationship to Patient

This authorization will expire one year from the date of the signature above. I understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.



Patient Name: _____ Date: _____

Please complete the following & please check one for each question

Due to having Parkinson's disease, how often during the last month have you:

Never (N) Occasionally (Oc) Sometimes (S) Often (Of) Always (A)

1. Had difficulty doing the leisure activities which you like to do? N Oc S Of A
2. Had difficulty looking after your home (DIY, housework, cooking)? N Oc S Of A
3. Had difficulty carrying shopping bags? N Oc S Of A
4. Had problems walking half a mile? N Oc S Of A
5. Had problems walking 100 yards? N Oc S Of A
6. Had problems getting around the house as easily as you would like? N Oc S Of A
7. Had difficulty getting around in public? N Oc S Of A
8. Needed someone else to accompany you when you went out? N Oc S Of A
9. Felt frightened or worried about falling over in public? N Oc S Of A
10. Been confined to the house more than you would like? N Oc S Of A
11. Had difficulty washing yourself? N Oc S Of A
12. Had difficulty dressing yourself? N Oc S Of A
13. Had problems doing up your shoe laces? N Oc S Of A
14. Had problems writing clearly? N Oc S Of A
15. Had difficulty cutting up your food? N Oc S Of A
16. Had difficulty holding a drink without spilling it? N Oc S Of A
17. Felt depressed? N Oc S Of A
18. Felt isolated and lonely? N Oc S Of A
19. Felt weepy or tearful? N Oc S Of A
20. Felt angry or bitter? N Oc S Of A
21. Felt anxious? N Oc S Of A
22. Felt worried about your future? N Oc S Of A
23. Felt you had to conceal your Parkinson's from people? N Oc S Of A
24. Avoided situations which involve eating or drinking in public? N Oc S Of A
25. Felt embarrassed in public due to having Parkinson's disease? N Oc S Of A
26. Felt worried by other people's reaction to you? N Oc S Of A
27. Had problems with your close personal relationships? N Oc S Of A
28. Lacked support in the ways you need from your spouse/ partner? N Oc S Of A
29. Lacked support in the ways you need from your family/ close friends? N Oc S Of A
30. Unexpectedly fallen asleep during the day? N Oc S Of A
31. Had problems with your concentration, e.g. when reading or watching TV? N Oc S Of A
32. Felt your memory was bad? N Oc S Of A
33. Had distressing dreams or hallucinations? N Oc S Of A
34. Had difficulty with your speech? N Oc S Of A
35. Felt unable to communicate with people properly? N Oc S Of A
36. Felt ignored by people? N Oc S Of A
37. Had painful muscle cramps or spasms? N Oc S Of A
38. Had aches and pains in your joints or body? N Oc S Of A
39. Felt unpleasantly hot or cold? N Oc S Of A

DIRECTIONS



SOUTH BOUND I-35

Exit PARMER LANE

Turn RIGHT onto PARMER

Get in immediate LEFT LANE, turn LEFT onto LAMAR BLVD.

Turn LEFT onto INDIAN MOUND

Turn RIGHT into PARK CENTRAL parking lot

Arrive at 12345 NORTH LAMAR BLVD., SUITE 260, AUSTIN, TX 78753

NORTH BOUND I-35

Exit YEAGER LANE

Turn LEFT onto YEAGER LANE

Turn RIGHT onto LAMAR

Turn RIGHT onto INDIAN MOUND

Turn RIGHT into PARK CENTRAL parking lot

Arrive at 12345 NORTH LAMAR BLVD., SUITE 260, AUSTIN, TX 78753