PARKPOINTHEALTHCLUB.COM

health history

EXERCISE FOR PEOPLE WITH PARKINSON'S

Name_____ DOB_____ Sex_____ Today's date_____

Phone_____ Cell_____ Email_____

Address_____ City_____ State_____ Zip_____

Physician name_____ Phone_____

Emergency contact name _____ Phone_____

What is your diagnosis?_____

_____

General symptoms (circle all that apply)

chills	sweats	weakness	fatigue	
blurred vision	double vision			
shortness of breath	chest pain	heart palpitations	fainting	light-headedness
nausea	excessive thirst	cold intolerance	heat intolerance	
back pain	joint pain	muscle pain	injury	decreased range of motion

Which symptom bothers you most?_____

What were your earliest symptom(s)? when did they start?_____

_____

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SEVERITY OF SYMPTOMS RATING SCALE FOR PARKINSON'S DISEASE

Please rate the severity of your symptoms on a scale from 0 to 4 with 4 being the most severe or most worrisome problem (circle one number for each problem)

0 = no problem or no concern	4 = severe problem or biggest concern				
problems with memory, thinking, focus, etc.	0	1	2	3	4
sleep	0	1	2	3	4
daytime sleepiness	0	1	2	3	4
pain	0	1	2	3	4
light-headedness	0	1	2	3	4
fatigue (not sleepiness)	0	1	2	3	4
speech	0	1	2	3	4
doing hobbies	0	1	2	3	4
tremor	0	1	2	3	4
getting out of bed, car, or chair	0	1	2	3	4
walking & balance	0	1	2	3	4
duration of dyskinesias/extra movement	0	1	2	3	4
severity of dyskinesias	0	1	2	3	4
depression	0	1	2	3	4
anxiety	0	1	2	3	4

Do you require assistance to stand or activities of daily living?_____

_____

PARKINSON'S OR MOVEMENT MEDICINE

med name & strength	a.m. morning time	afternoon/evening time	p.m. night time

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ORTHOPEDIC

Do you have any of the following conditions that may limit your physical activity? (circle all that apply)

ankle/foot injury	bone fracture	shoulder/clavicle injury	arthritis
low back pain	nerve damage	arm/elbow injury	knee/thigh injury
hip/pelvic injury	upper back injury	wrist/hand injury	other

Please explain_____

_____

MEDICAL HISTORY

Check if applicable	Yes	No	If yes, describe
diabetes			
high blood pressure			
high cholesterol			
angina/chest pain			
heart murmur			
irregular heart beats			
abnormal electrocardiogram			
rheumatic fever			
thrombophlebitis			
respiratory infections			
thyroid disease			
embolism			
aneurysm			
stroke			
valve disease			
heart attack			
asthma			
osteoporosis			
epilepsy			
headaches/migraines			

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EXERCISE PROFILE

Are you presently receiving physical therapy or working with a trainer? _____yes _____no

If so, where?_____

Indicate your daily activity level

(sedentary) 1 2 3 4 5 6 7 8 9 10 (strenuous)

Indicate how you are dealing with daily stress

(not coping well) 1 2 3 4 5 6 7 8 9 10 (coping well)

Indicate your energy level

(extremely low) 1 2 3 4 5 6 7 8 9 10 (extremely high)

How many hours of sleep do you normally get per night?_____

Additional information you would like us to know_____

_____

_____