



Parkinson's Questionnaire: Activities of Daily Living

(Modified from the "Assessment of the activities of daily living to help evaluate disease progression and effectiveness of therapy for Parkinson's patients" questionnaire, by Stanley Fahn, MD)

1. General instructions:

- Step 1. Read each of the following 13 questions carefully, and then think about how you have been in the past week.
- Step 2. Read through each of the possible answers carefully, and choose one that best describes how you feel. For comparison, think of how you used to be before you were diagnosed with Parkinson's disease.
- Step 3. On the left side of each question, there are five yellow check boxes. Make a check mark in the box on the same line as the answer you chose. Unless you have "on" and "off" periods (see below) ignore the blue boxes.

2. Special instructions for patients with "on" and "off" periods.

Up to 50% of patients with Parkinson's disease who take levodopa or dopamine agonists will develop what we call "on" and "off" periods. These are times when your Parkinson's symptoms are significantly better or worse than at other times, due to rising and falling levels of medication in the brain. If you know that you have "on" and "off" periods, or think you do, you will want to tell us how you are both when you are feeling better ("on") and worse ("off"). In this case, do not use the yellow boxes. Use the blue boxes, and for each question, make two marks; one for when you are "on" and one for when you are "off."

on off 1. Do you have problems with your speech?

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 0. No, my speech is normal. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Yes, my speech is mildly affected, but I have no difficulty being understood. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Yes, my speech is moderately affected and I am sometimes asked to repeat myself. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Yes, my speech is severely affected and I am sometimes asked to repeat myself. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Yes, my speech is so severely affected that it is very hard for people to understand me. |

on off 2. Do you have too much saliva?

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 0. No, I do not have too much saliva and I never drool. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Yes, I have a slight excess of saliva. Sometimes I drool onto my pillow at night. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Yes, I have a moderate excess of saliva and I occasionally drool during the daytime. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Yes, I have a marked excess of saliva and I often drool during the daytime. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Yes, I have so much drooling that I often carry a tissue or handkerchief. |

on off 3. Do you have problems swallowing or do you choke on your food?

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 0. No, I do not have a problem with swallowing, and I do not choke. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Yes, I have problems with swallowing, but I rarely choke. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Yes, I have problems with swallowing and occasionally choke. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Yes, I have problems with swallowing requiring me to eat soft food. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Yes, I am unable to swallow and must use a nasogastric or gastrostomy tube. |

on off 4. Have you noticed a change in your handwriting? Do you have difficulty writing?

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 0. No, my handwriting is normal. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Yes, my handwriting is slightly slow or small. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Yes, my handwriting is moderately slow or small, but all of the words are readable. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Yes, my handwriting is severely affected. Not all of the words are readable. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Yes, my handwriting is severely affected. Most of the words are not readable. |

on off 5. Do you have slowness or difficulty using utensils or cutting your food?

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 0. No, I do not have slowness or difficulty using utensils or cutting my food. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Yes, I am a little slow or clumsy, but I am able to feed myself without help. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Yes, I am slow and clumsy. I need help cutting some types of food. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Yes, my food must be cut by someone, but I am still able to feed myself. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Yes, I am unable to feed myself. Someone else feeds me. |

on off 6. Do you have slowness or difficulty getting dressed?

- 0. No, I do not have slowness or difficulty with dressing.
- 1. Yes, I am a little slow, but I don't need help.
- 2. Yes, I am slow and sometimes need help with buttons, shoe laces, or getting my arm into a sleeve.
- 3. Yes, I need a lot of help getting dressed, but I can still do some things alone.
- 4. Yes, I am unable to get dressed without assistance.

on off 7. Have you slowed down or are you experiencing problems with hygiene? (see note 1)

- 0. No, I am not slow with these activities.
- 1. Yes, I am a little slow with my hygiene, but I do not need help.
- 2. Yes, I am slow with my hygiene and I need help to shower and bathe.
- 3. Yes, I need help with washing, brushing my teeth, combing my hair, and going to the bathroom.
- 4. Yes, I need help with all of my hygiene and I have a Foley catheter.

on off 8. Do you have difficulty turning in bed or adjusting the sheets?

- 0. No, I do not have difficulty turning in bed or adjusting the sheets.
- 1. Yes, I am a little clumsy or slow with turning in bed and adjusting the sheets, but do not need help.
- 2. Yes, I am only able to turn or adjust the sheets with great difficulty.
- 3. Yes, I am able to start turning, but am unable to do it without help.
- 4. Yes, I am unable to turn in bed or adjust the sheets without help.

on off 9. Do you have problems with falling?

- 0. No, I do not fall.
- 1. Yes, but I rarely fall.
- 2. Yes, I occasionally fall, but less than once per day.
- 3. Yes, I fall an average of one time per day.
- 4. Yes, I fall an average of more than one time per day.

on off 10. Do you have freezing while you are walking? (see note 2)

- 0. No, I do not have "freezing."
- 1. Yes. Rarely, or sometimes, when I first start to walk, I have "freezing."
- 2. Yes, I occasionally have "freezing" when I walk.
- 3. Yes, I frequently have "freezing" when I walk I occasionally fall because of the "freezing."
- 4. Yes, I frequently have "freezing" when I walk I frequently fall because of the "freezing."

on off 11. Has your walking changed? Is it difficult to walk?

- 0. No, My walking and my arm swing have not changed.
- 1. Yes, I don't swing my arm or I tend to drag my leg.
- 2. Yes, I have a moderate amount of difficulty with walking, but usually don't need assistance.
- 3. Yes, I have severe problems with walking and usually need assistance.
- 4. Yes, I can't walk at all, even when someone tries to help me.

on off 12. Do you have a visible tremor anywhere in your body?

- 0. No, I do not have a visible tremor.
- 1. Yes, I have a slight visible tremor that is infrequently present.
- 2. Yes, I have a moderate amount of tremor. The tremor bothers me.
- 3. Yes, I have a severe tremor and it interferes with many activities.
- 4. Yes, I have a severe tremor that interferes with most activities.

on off 13. Do you have numbness, tingling, discomfort, or aching due to Parkinson's?

- 0. No, I do not have numbness, tingling, or aching due to Parkinson's disease
- 1. Yes, I have occasional numbness, tingling, or aching due to Parkinson's disease
- 2. Yes, I frequently have numbness, tingling, or aching due to Parkinson's disease
- 3. Yes, I have frequent painful sensations due to Parkinson's disease
- 4. Yes, I have excruciating pain due to Parkinson's disease

Note 1: Hygiene means bathing, brushing your teeth, combing your hair, and going to the bathroom.

Note 2: "Freezing" occurs when you are unable to walk for a few seconds because your feet seem to be stuck to the ground