



Please rate (circle #) how each symptom below bothers you on a scale from 0 to 5.

**0 = No Problem or No Concern**

**5 = Severe Problem or Biggest Concern**

Writing	0	1	2	3	4	5
Fine Hand Movement	0	1	2	3	4	5
Bathing, Dressing	0	1	2	3	4	5
Walking	0	1	2	3	4	5
Falls	0	1	2	3	4	5
Freezing	0	1	2	3	4	5
Dyskinesia	0	1	2	3	4	5
Muscle Spasm	0	1	2	3	4	5
Wearing Off	0	1	2	3	4	5
Bladder Problems	0	1	2	3	4	5
Sexual Function	0	1	2	3	4	5
Speech	0	1	2	3	4	5
Swallowing	0	1	2	3	4	5
Sleep	0	1	2	3	4	5
Impulsivity	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5
Motivation	0	1	2	3	4	5
Thinking	0	1	2	3	4	5
Hallucinations	0	1	2	3	4	5
Pain	0	1	2	3	4	5
Constipation	0	1	2	3	4	5
Lightheaded	0	1	2	3	4	5
Chest Pain or Palpitations	Yes			No		
Cough or Sore Throat	Yes			No		
Rash or Bruising	Yes			No		
Leg Swelling	Yes			No		
Joint Pain	Yes			No		
Heartburn or Upset Stomach	Yes			No		
Fatigue	Yes			No		
Seizures	Yes			No		
Hearing Loss	Yes			No		
Double or Blurred Vision	Yes			No		
Headache	Yes			No		