PARKINSON'S DISEASE QUALITY OF LIFE QUESTIONNAIRE

NAME:	DATE:	Page 1

PLEASE USE PENCIL! This questionnaire has 37 questions which will help us to know how you're feeling. Please do not leave out any questions; it is important that they are all answered. Place an X in the box that you feel shows how much of a problem each one has been for you *in the past 3 months.*

	How often have you had trouble with	All the time	Most of the time	Some of the time	A little of the time	Never
1	Stiffness?					
2	Feeling generally unwell?					
3	Feeling that you are no longer able to do your hobbies?					
4	Being tense?					
5	Feeling insecure of yourself due to your physical limitations?					
6	Shaking of your hand(s)?					
7	Feeling worn out or having no energy?					
8	Difficulties in doing sport or leisure activities?					
9	Clumsiness?					
10	Feeling embarrassed about your illness?					
11	Shuffling when you walk?					
12	Having to postpone or cancel social activities because of your illness?					
13	A feeling of extreme exhaustion?					
14	Difficulties turning around while walking?					
15	Being afraid of possible progressing of the illness?					
16	Difficulties writing?					
17	Being less able to go on vacation than before your illness?					
18	Feeling insecure of yourself around others?					

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	How often have you had trouble with	All the time	Most of the time	Some of the time	A little of the time	Never
19	Difficulties getting a good night's rest?					
20	"On/Off" periods?					
21	Difficulty in acceptiong your illness?					
22	Difficulties talking?					
23	Difficulties signing your name in public?					
24	Difficulties walking?					
25	Drooling?					
26	Feeling depressed or discouraged?					
27	Difficulty with sitting still (for long periods)?					
28	Often needing to urinate and/or wetting yourself?					
29	Difficulties with transport?					
30	Sudden extreme movements?					
31	Difficulties concentrating?					
32	Difficulties getting up from a chair?					
33	Constipation?					
34	Difficulties with your memory?					
35	Difficulties turning around in bed?					
36	That your illness inhibits your sex life?					
37	Feeling worried about (the possible consequences of) an operation in connection with your illness?					
	Did you need any help to complete this questionnaire?		yes ( )		no ( )	
	If yes, who? Partner/Spouse? ( ) Friend/neighbor ( ) Family member ( ) Nurse ( ) Other (please specify) ( )					