

Non-Motor Symptom assessment scale for Parkinson's Disease

Patient ID No: _____ Initials: _____ Age: _____

Symptoms assessed over the last month. Each symptom scored with respect to:

Severity: 0 = None, 1 = Mild: symptoms present but causes little distress or disturbance to patient; 2 = Moderate: some distress or disturbance to patient; 3 = Severe: major source of distress or disturbance to patient.

Frequency: 1 = Rarely (<1/wk); 2 = Often (1/wk); 3 = Frequent (several times per week); 4 = Very Frequent (daily or all the time)

Domains will be weighed differentially. Yes/ No answers are not included in final frequency x severity calculation. (Bracketed text in questions within the scale is included as an explanatory aid).

Domain 1: Cardiovascular including falls

1. Does the patient experience light-headedness, dizziness, weakness on standing from sitting or lying position?
2. Does the patient fall because of fainting or blacking out?

Severity	Frequency	Frequency x Severity
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCORE:

Domain 2: Sleep/fatigue

3. Does the patient doze off or fall asleep unintentionally during daytime activities? (For example, during conversation, during mealtimes, or while watching television or reading).
4. Does fatigue (tiredness) or lack of energy (not slowness) limit the patient's daytime activities?
5. Does the patient have difficulties falling or staying asleep?
6. Does the patient experience an urge to move the legs or restlessness in legs that improves with movement when he/she is sitting or lying down inactive?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCORE:

Domain 3: Mood /Cognition

7. Has the patient lost interest in his/her surroundings?
8. Has the patient lost interest in doing things or lack motivation to start new activities?
9. Does the patient feel nervous, worried or frightened for no apparent reason?
10. Does the patient seem sad or depressed or has he/she reported such feelings?
11. Does the patient have flat moods without the normal "highs" and "lows"?
12. Does the patient have difficulty in experiencing pleasure from their usual activities or report that they lack pleasure?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCORE:

Domain 4: Perceptual problems/hallucinations

13. Does the patient indicate that he/she sees things that are not there?
14. Does the patient have beliefs that you know are not true? (For example, about being harmed, being robbed or being unfaithful)
15. Does the patient experience double vision? (2 separate real objects and not blurred vision)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCORE:

Severity **Frequency** **Frequency
x Severity**

Domain 5: Attention/ Memory

16. Does the patient have problems sustaining concentration during activities?
(For example, reading or having a conversation)
17. Does the patient forget things that he/she has been told a short time ago or events that happened in the last few days?
18. Does the patient forget to do things?
(For example, take tablets or turn off domestic appliances?)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCORE:

Domain 6: Gastrointestinal tract

19. Does the patient dribble saliva during the day?
20. Does the patient having difficulty swallowing?
21. Does the patient suffer from constipation?
(Bowel action less than three times weekly)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCORE:

Domain 7: Urinary

22. Does the patient have difficulty holding urine? (Urgency)
23. Does the patient have to void within 2 hours of last voiding? (Frequency)
24. Does the patient have to get up regularly at night to pass urine? (Nocturia)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCORE:

Domain 8: Sexual function

25. Does the patient have altered interest in sex?
(Very much increased or decreased, please underline)
26. Does the patient have problems having sex?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCORE:

Domain 9: Miscellaneous

27. Does the patient suffer from pain not explained by other known conditions?
(Is it related to intake of drugs and is it relieved by antiparkinson drugs?)
28. Does the patient report a change in ability to taste or smell?
29. Does the patient report a recent change in weight (not related to dieting)?
30. Does the patient experience excessive sweating? (not related to hot weather)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCORE:

TOTAL SCORE: