Conversation Companion

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BE YOUR BEST SELF

Please fill this out and bring it with you to your next appointment. It will help you have a more productive conversation with your doctor.

PART 1: My Symptoms

Noting which symptoms are new and which are getting worse may help your doctor get a better idea of how well your current treatment is working.

Motor Symptoms	New	Worse
Uncontrollable, involuntary movements, such as twitches, jerking, and twisting motions of the face and body **(dyskinesia)**		
Rigidity		
Slowness of movement		
Tremors		
Difficulties with posture		
Freezing in place while walking		
Shuffling or slow walking		
Reduced facial expression		
Small handwriting		
Voice and speech changes		
Swallowing problems		
Other:		

PART 1: My Symptoms

(continued)

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Non-Motor Symptoms	New	Worse
Changes in mood and thinking		
Sleep issues		
Tiredness		
Pain		
Stomach issues		
Poor bladder control		
Other:		

Additional Notes:

PART 2: My "Good On" Time

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Question	Answer
1. After you take your medicine, **how soon** do you feel you are experiencing "On" time?	
2. **How long does your "On" time last** with each of your doses throughout the day?	Dose 1: Dose 2: Dose 3: Dose 4: Dose 5: Additional doses:
3. Think about the total "On" time you have each day. **How much of that time would you consider to be "Good On" time?** As a reminder, "Good On" time is when your symptoms are controlled, and you are not experiencing those movements that you cannot control, such as twitches, jerks, and twisting motions of the face and body.	
4. **For each of your daily doses, how much time do you experience "Good On" time?** Are there **certain doses after which you or your care partner notice you are not experiencing "Good On" time?** Make a note of which doses they are so that you can speak with your doctor about it.	

PART 2: My “Good On” Time
(continued)

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Question	Answer
5. Approximately **how many hours of “Off” time** do you experience each day? As a reminder, “Off” time is when your symptoms of Parkinson’s occur.	
6. Approximately **how many times do you go back and forth** between “Off” and “On” time each day?	

7. Which of the following statements **best describe your experiences?** (Check all that apply.)

- ☐ My “Off” time is unpredictable so it is hard to know how my day will go.
- ☐ I don’t think my medication is working as well as it used to.
- ☐ Each dose of my medication seems to wear off more quickly than it used to.
- ☐ I experience “Off” time more frequently between doses of my medication.

My treatment goals

Which of the following statements best describe **your experiences with treatment?** (Check all that apply.)

- ☐ I would prefer a medication that lasts longer.
- ☐ I think my medication works well; I just wish it wouldn’t wear off so quickly.
- ☐ I would prefer to take my medication less often.
- ☐ I prefer to not take multiple kinds of medication.
- ☐ I am nervous about trying a new type of medication.
- ☐ I would like a medication that can increase my “Good On” time.

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