ICICLE-PD Study

Participant History

Participant ID number: Date of review:

DOB: Location of assessment:

Ethnicity: Name of assessor:

Handedness: R / L Referral source:

Country of birth: Caregiver/ carer present: Y/ N

English proficiency Y/ N English as first language Y/ N

Parkinson's Disease/ Parkinsonism History:

Symptom(s):

Tremor (resting) □ RUL/ LUL/ RLL/ LLL/ other: _____

Rigidity ('stiffness') □ RUL/ LUL/ RLL/ LLL/ other: _____

Akinesia/ Bradykinesia □ RUL/ LUL/ RLL/ LLL/ other: _____

Postural instability/ gait dysfunction □ Features: falls/ off balance/ ↓confidence in mobility
Other (incl no. of falls): _____

Other symptoms (see page 8 PD NMS for guidance):

Have you noticed any change in smell or taste? smell/ taste/ both/ not applicable/ other:
Duration:

		Duration			Duration
Dribbling	□		Delusions	□	
Swallowing	□		Low mood/ sad	□	
Nausea/ vomiting	□		Anxiety	□	
Constipation	□		Sex drive	□	
Bowel incontinence	□		Sex difficulty	□	
Bowel emptying incompletely	□		Dizzy	□	
Urinary urgency	□		Falling	□	
Nocturia	□		Daytime sleepiness	□	
Forgetfulness, memory	□		Insomnia	□	
Loss of interest	□		Restless legs	□	
Concentration	□		Hallucinations	□	
Swelling (lower limbs)	□		Double vision	□	
Pains (unexplained)	□		Hyperhidrosis	□	

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Sleep/ RBD:
Have you ever seen the patient appear to "act out his/her dreams" while sleeping? (punched or flailed arms in the air; shouted or screamed) Yes/ No (Duration:)

Has the subject told you about dreams of being chased, attacked, or that involve defending himself or herself? Yes/ No (Duration:)

MDS-UPDRS 1.4	
MDS-UPDRS 1.5	

Gastro: bowel habit: normal/ abnormal Frequency:

Weight: gain/ steady/ loss (In NPI) Estimated amount/ duration:
Intentional/ unintentional

Onset of first symptoms (date/month/year)/ duration:

Onset: sudden (acute)/ gradual

Side of onset of initial symptoms: R/ L/ symmetrical

Response to DA medication:

Poor	0-25%	Good	50-75%
Moderate	25-50%	Excellent	75-100%

Relieving factors:

Aggravating factors:

Symptom progression:

Is there a diurnal variation of symptoms? Yes/ No

Additional notes:

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Other medical issues/ Past medical history:

Issue	Date of onset		Issue	Date of onset

Allergies: NKDA/ _____

Current medications:

Name of medication	Dose/ frequency	Commenced on (approximately)

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Use of complimentary medical products: Y/ N

Family History
Family tree:

Number of siblings:

Illnesses that run in the family:

Does anyone else in the family have a movement disorder/ Parkinson's disease/ dementia?
If yes, please provide more details:

Does anyone in the immediate family have a history of depression?

Social History

Marital state: Single/ Married (living with partner)/ Separated/ Divorced/ Widowed

Home: own residence/ renting/ placement (residential care)/ other:

ADLs: independent ADLs/ assisted ADLs – if assisted, please define:
pADL/ dADL/ cADL

Occupation:

Highest education level:

Smoker/ Ex-smoker/ Non-smoker

If applicable; approximate no. of pack years: _____

Caffeine intake: _____ units/ wk (1 units = 1 cup tea/ coffee/ coke)

Alcohol intake: _____units/ week
Any history of previous alcohol excess? Yes/ No

Any history of recreational drug/ substance misuse: Yes/ No

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Systems review

CNS: headache/ paraesthesia/ seizures/ hearing impairment/ visual symptoms/

Vision: corrected/ uncorrected. If applicable, visual aid used:

Ψ history mood disorders/ depression/ mania/ other: _____

CVS/ respiratory: palpitations/ chest pain/ breathlessness/ cough/ sputum/ wheeze

Miscellaneous/ Other:

Clinical Examination

Cranial nerves:
I
II Acuity
Colour vision Normal/ Abnormal
Accommodation
Visual fields
Fundoscopy

III, IV & VI

V Sensory
Motor

VII
VIII
IX & X
XI
XII

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Limbs

Reflexes:

MDS-UPDRS

	RUL	LUL	RLL	LLL
Tone				
Power				
Sensation				
Coordination				

Gait:

Grading of tone, reflexes and coordination
- = not present/ undetectable
+ = decreased
N/++ = normal
+++ = increased
Grading of power via MRC scale
0 - no movement
1 - flicker is perceptible in the muscle
2 - movement only if gravity eliminated
3 - can move limb against gravity
4 - can move against gravity & some resistance exerted by examiner
5 - normal power

Timed motor tests:

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UK Brain Bank Criteria checklist

UK Parkinson's Disease Society Brain Bank Clinical Diagnostic Criteria

(Hughes AJ et al. J Neurol Neurosurg Psychiatry 1992;55:181-4)

Inclusion criteria	Exclusion criteria	Supportive criteria
Bradykinesia (slowness of initiation of voluntary movement with progressive reduction in speed and amplitude of repetitive actions)	History of repeated strokes with stepwise progression of parkinsonian features	(Three or more required for diagnosis of definite PD)
	History of repeated head injury	Unilateral onset
	History of definite encephalitis	Rest tremor present
And at least one of the following:	Oculogyric crises	Progressive disorder
Muscular rigidity	Neuroleptic treatment at onset of symptoms	Persistent asymmetry affecting side of onset most
4-6 Hz rest tremor	More than one affected relative	Excellent response (70-100%) to levodopa
Postural instability not caused by primary visual, vestibular, cerebellar, or proprioceptive dysfunction	Sustained remission	Severe levodopa-induced chorea
	Strictly unilateral features after 3 yr	Levodopa response for 5 yr or more
	Supranuclear gaze palsy	Clinical course of 10 yr or more
	Cerebellar signs	
	Early severe autonomic involvement	
	Early severe dementia with disturbances of memory, language, and praxis	
	Babinski sign	
	Presence of cerebral tumour or communicating hydrocephalus on CT scan	
	Negative response to large doses of L-dopa (if malabsorption excluded)	
	MPTP exposure	

Relevant investigations previously performed:

CT brain _____

MRI brain _____

FP-CIT SPECT (DatSCAN) _____

Other: _____

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The PD NMS Questionnaire is only for guidance when taking the Parkinson's disease/ Parkinsonism history.

PD NMS QUESTIONNAIRE

Name: ..... Date: ..... Age: .....

Centre ID: Male ☐ Female ☐

NON-MOVEMENT PROBLEMS IN PARKINSON'S

The movement symptoms of Parkinson's are well known. However, other problems can sometimes occur as part of the condition or its treatment. It is important that the doctor knows about these, particularly if they are troublesome for you.

A range of problems is listed below. Please tick the box 'Yes' if you have experienced it **during the past month.** The doctor or nurse may ask you some questions to help decide. If you have **not** experienced the problem in the past month tick the 'No' box. You should answer 'No' even if you have had the problem in the past but not in the past month.

Have you experienced any of the following in the last month?

	Yes	No
1. Dribbling of saliva during the daytime	☐	☐
2. Loss or change in your ability to taste or smell	☐	☐
3. Difficulty swallowing food or drink or problems with choking	☐	☐
4. Vomiting or feelings of sickness (nausea)	☐	☐
5. Constipation (less than 3 bowel movements a week) or having to strain to pass a stool (faeces)	☐	☐
6. Bowel (fecal) incontinence	☐	☐
7. Feeling that your bowel emptying is incomplete after having been to the toilet	☐	☐
8. A sense of urgency to pass urine makes you rush to the toilet	☐	☐
9. Getting up regularly at night to pass urine	☐	☐
10. Unexplained pains (not due to known conditions such as arthritis)	☐	☐
11. Unexplained change in weight (not due to change in diet)	☐	☐
12. Problems remembering things that have happened recently or forgetting to do things	☐	☐
13. Loss of interest in what is happening around you or doing things	☐	☐
14. Seeing or hearing things that you know or are told are not there	☐	☐
15. Difficulty concentrating or staying focussed	☐	☐
16. Feeling sad, 'low' or 'blue'	☐	☐
17. Feeling anxious, frightened or panicky	☐	☐
18. Feeling less interested in sex or more interested in sex	☐	☐
19. Finding it difficult to have sex when you try	☐	☐
20. Feeling light headed, dizzy or weak standing from sitting or lying	☐	☐
21. Falling	☐	☐
22. Finding it difficult to stay awake during activities such as working, driving or eating	☐	☐
23. Difficulty getting to sleep at night or staying asleep at night	☐	☐
24. Intense, vivid dreams or frightening dreams	☐	☐
25. Talking or moving about in your sleep as if you are 'acting' out a dream	☐	☐
26. Unpleasant sensations in your legs at night or while resting, and a feeling that you need to move	☐	☐
27. Swelling of your legs	☐	☐
28. Excessive sweating	☐	☐
29. Double vision	☐	☐
30. Believing things are happening to you that other people say are not true	☐	☐

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