CHECKLIST

YES	NO	
☐	☐	Are you tired most of the day?
☐	☐	Do you have numbness, tingling or aching?
☐	☐	Are you often constipated?
☐	☐	Have you or your care partner noticed changes in your thinking, e.g., solving problems or remembering things?
☐	☐	Have people mentioned they have difficulty understanding you when you speak?
☐	☐	Do you have problems swallowing or choking on your food?
☐	☐	Have you suddenly “dozed off” while engaged in an activity (e.g., eating a meal or having a conversation)?
☐	☐	Has your handwriting changed in the last 6 months?
☐	☐	Have you fallen down in the last 6 months? If so, how many times?
☐	☐	Do you “freeze” (stop suddenly) when walking?
☐	☐	Have you or your care partner noticed changes in your ability to drive the car?
☐	☐	Has your partner noticed you are having violent dreams?
☐	☐	Do you feel sad for several days at a time?
☐	☐	Are you experiencing changes with sexual function (e.g., no interest/performance/or “hyper” interest)?
☐	☐	Do your medications take a longer time before they start working?
☐	☐	Have you noticed your medications work for a shorter period of time?
☐	☐	Do you have urinary problems?
☐	☐	Do you feel light-headed or dizzy when you get up from a chair or bed?
☐	☐	Have you or your care partner noticed that you are shopping more often or have a keen desire to buy lottery tickets or to play slot machines?
☐	☐	Have you noticed a change in your sense of smell?