Power Over Parkinsons Program
Intake Form

Client Information

First Name:	
Last Name:	
Date of Birth: (MM/DD/YR)	Age:
Sex (Circle): Male Female Other Prefer not to disclose	

Contact Information

Home Address:	
Home Phone #:	Cell Phone #:
Email:	

Emergency Contact Information

Name:	
Relationship:	
Home Address:	
Home Phone #:	Cell Phone #:
Email:	

Medical Information

Family Doctor Name
Medical Practice Name:
Location (Town/City) of Medical Practice:

Specialist Doctor Name (if applicable):
Location (Town/City) of Medical Practice

Parkinson Specific Medical History

Date of your diagnosis of Parkinson's Disease: (MONTH/YEAR) _____
Have you experienced a fall in the past 12 months: YES/NO
How many falls have you experienced in the past 12 months: #_____
Are you fearful of falling or avoid certain activities out of concern of falling? YES / NO What activities of daily living cause you the greatest concern of falling?

Please circle YES or NO to provide information on any **CURRENT symptoms that you are experiencing that** are commonly experienced by people with Parkinson's Disease

Orthostatic hypotension (Low blood pressure episodes with a change in positions)	YES/NO
Dysphagia (difficulty swallowing)	YES/NO
Tremors	YES/NO
Rigidity (stiffness in any limbs or joints)	YES/NO
Bradykinesia (slowed movements)	YES/NO
Other (please describe)	YES/NO

Medical History
Please circle YES or NO to provide information on the medical conditions or chronic disease(s) if any, that you are **CURRENTLY** managing or **HAVE EXPERIENCED** in the past:

Hypertension	YES/NO
Heart Disease	YES/NO
Heart Failure	YES/NO
Angina	YES/NO
Pacemaker	YES/NO
Myocardial Infraction (Heart Attack)	YES/NO
Hypercholesterolemia (High Cholesterol)	YES/NO
Stroke	YES/NO
Diabetes	YES/NO
Anemia	YES/NO
Asthma	YES/NO
Chronic Obstructive Pulmonary Disease	YES/NO
Hearing loss (requiring aides)	YES/NO
Arthritis (Rheumatoid or Osteo)	YES/NO
Cataracts	YES/NO
Cognitive Decline/Dementia	YES/NO
Osteoporosis	YES/NO
Depression	YES/NO
Anxiety	YES/NO
Smoking	YES/NO
Joint Replacement Joint(s):	YES/NO
Cancer Type:	YES/NO
Musculoskeletal Injury (muscle/bones/joints) Type:	YES/NO
Other (please list):	YES/NO

Medication Information
Please provide a detailed list of the **prescribed medication(s)** you are **currently** taking.

DRUG NAME	DOSE (amount & timing)	CONDITION reason it is prescribed

INFORMED CONSENT- Power over Parkinsons Program

As a registered participant in the Power over Parkinsons program, I, _____ acknowledge that I will be required to actively participate in an exercise program that includes an assessment of my health, lifestyle, and fitness level at the beginning and end of the program that will include:

1. Providing personal information about my physical activity, sedentary behaviour, medical history, and other lifestyle factors.
2. Measures of resting heart rate and blood pressure.
3. Measures of musculoskeletal fitness.
4. Measures of gait, balance, and mobility.
5. Measures of aerobic fitness.
6. Measures of quality of life and freezing gait specific to Parkinsons Disease.
7. Exercise training that includes two sessions per week of supervised exercise.
8. Post-program evaluation of physical and program outcomes.

I further acknowledge that:

1. I have completed a pre-participation health screening (PARQ+) and have been deemed ready to participate in physical activity.

2. All testers and trainers are trained and certified in first aid and basic CPR.

3. There are potential benefits of participating in the program; improved cardiovascular fitness, increased strength, and overall improvement in health and wellness.

4. There are small but potential risks associated with participation in exercise; i.e. episodes of transient lightheadedness, fainting, chest discomfort, leg cramps and nausea. The risks associated with participation do not exceed participation in regular physical activities. To reduce the risk of musculoskeletal injury during participation, you will participate in a standardized warm up and cool down as part of the exercise session.

5. I will use any prescribed medication as per the direction of the medical professional from whom it was prescribed during the program.

6. I am obligated to immediately notify the Instructor of any pain, discomfort, fatigue or any other symptoms that I may experience at any time during and immediately after the program session.

7. I may stop or delay the testing and training at any time if I so desire and that the testing and training may be terminated by the appraiser upon observation of any symptoms of distress or abnormal response.

8. I may ask questions or request further information about the procedures at any time before, during and after the testing and training, and I have the right to refuse to answer any questions being asked.

9. The information collected over the course of this program ***will only*** be used for research and program evaluation if provide my consent.

10. All data collected in the program will be kept on a personal computer that is locked with a password and on Acadia University cloud-based OneDrive. Data will be kept confidential and de-identified prior to analyzing the results. It should be noted, however, any data sent electronically or stored online may be legally accessed by domestic or foreign authorities.

The data collected from the fitness assessments and the exercise program can provide meaningful information on the improvements in health through physical activity programming in older adults. We may be able to use this data in the future when applying for grant funds for similar programs or for publication in peer-reviewed journals.

Please let us know if you give us permission to use your data in the future by checking one of the statements provided below. As mentioned above, your data will remain anonymous, and your confidentiality will be protected.

☐ My data can be used in the future for research purposes.

☐ Please do not use my data for future research purposes.

Please let us know if you would like to receive information on future programs be checking one of the boxes below:

☐ I would like to receive information on future physical activity and exercise programs.

☐ I do not wish to receive information on future physical activity and exercise programs.

I acknowledge my consent to participate as outlined above in the Power over Parkinson Program.

_____

Name of Participant

_____ _____

Signature of Participant Date

_____ _____

Signature of Witness Date

PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or **NO**.	YES	NO
1) Has your doctor ever said that you have a heart condition ☐ **OR** high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it **does not limit your current ability** to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.
Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (https://www.who.int/publications/i/item/9789240015128).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:

- You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
- You are pregnant. In this case, talk with your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes. Answer the questions on Pages 2 and 3 of this document and/or talk to your health care practitioner, physician, or qualified exercise professional before proceeding with any physical activity program.

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PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c — If **NO** ☐ go to question 2

1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	YES ☐ NO ☐
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	YES ☐ NO ☐

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b — If **NO** ☐ go to question 3

2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	YES ☐ NO ☐
2b.	Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	YES ☐ NO ☐

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d — If **NO** ☐ go to question 4

3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	YES ☐ NO ☐
3c.	Do you have chronic heart failure?	YES ☐ NO ☐
3d.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	YES ☐ NO ☐

4. Do you currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b — If **NO** ☐ go to question 5

4a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
4b.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	YES ☐ NO ☐

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/are present, answer questions 5a-5e — If **NO** ☐ go to question 6

5a.	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?	YES ☐ NO ☐
5b.	Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	YES ☐ NO ☐
5c.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?	YES ☐ NO ☐
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	YES ☐ NO ☐
5e.	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	YES ☐ NO ☐

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6. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b — If **NO** ☐ go to question 7

6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
6b.	Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	YES ☐ NO ☐

7. Do you have a Respiratory Disease? *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

If the above condition(s) is/are present, answer questions 7a-7d — If **NO** ☐ go to question 8

7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
7b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	YES ☐ NO ☐
7c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	YES ☐ NO ☐
7d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	YES ☐ NO ☐

8. Do you have a Spinal Cord Injury? *This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 8a-8c — If **NO** ☐ go to question 9

8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
8b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	YES ☐ NO ☐
8c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	YES ☐ NO ☐

9. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

If the above condition(s) is/are present, answer questions 9a-9c — If **NO** ☐ go to question 10

9a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
9b.	Do you have any impairment in walking or mobility?	YES ☐ NO ☐
9c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	YES ☐ NO ☐

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c — If **NO** ☐ read the Page 4 recommendations

10a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	YES ☐ NO ☐
10b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	YES ☐ NO ☐
10c.	Do you currently live with two or more medical conditions?	YES ☐ NO ☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: _____

_____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

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If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
- You are pregnant. In this case, talk to your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes. Talk to your health care practitioner, physician, or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact

www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

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PDQ-39 QUESTIONNAIRE

Please complete the following

Please tick <u>one</u> box for each question

Due to having Parkinson's disease, how often <u>during the last month</u> have you....		**Never**	**Occasionally**	**Sometimes**	**Often**	**Always** or cannot do at all
1	Had difficulty doing the leisure activities which you would like to do?	☐	☐	☐	☐	☐
2	Had difficulty looking after your home, e.g. DIY, housework, cooking?	☐	☐	☐	☐	☐
3	Had difficulty carrying bags of shopping?	☐	☐	☐	☐	☐
4	Had problems walking half a mile?	☐	☐	☐	☐	☐
5	Had problems walking 100 yards?	☐	☐	☐	☐	☐
6	Had problems getting around the house as easily as you would like?	☐	☐	☐	☐	☐
7	Had difficulty getting around in public?	☐	☐	☐	☐	☐
8	Needed someone else to accompany you when you went out?	☐	☐	☐	☐	☐
9	Felt frightened or worried about falling over in public?	☐	☐	☐	☐	☐
10	Been confined to the house more than you would like?	☐	☐	☐	☐	☐
11	Had difficulty washing yourself?	☐	☐	☐	☐	☐
12	Had difficulty dressing yourself?	☐	☐	☐	☐	☐
13	Had problems doing up your shoe laces?	☐	☐	☐	☐	☐

*Please check that you have ticked **one box for each question** before going on to the next page*

Due to having Parkinson's disease, how often <u>during the last month</u> have you....		***Please tick <u>one</u> box for each question***				
		Never	**Occasionally**	**Sometimes**	**Often**	**Always** or cannot do at all
14	Had problems writing clearly?	☐	☐	☐	☐	☐
15	Had difficulty cutting up your food?	☐	☐	☐	☐	☐
16	Had difficulty holding a drink without spilling it?	☐	☐	☐	☐	☐
17	Felt depressed?	☐	☐	☐	☐	☐
18	Felt isolated and lonely?	☐	☐	☐	☐	☐
19	Felt weepy or tearful?	☐	☐	☐	☐	☐
20	Felt angry or bitter?	☐	☐	☐	☐	☐
21	Felt anxious?	☐	☐	☐	☐	☐
22	Felt worried about your future?	☐	☐	☐	☐	☐
23	Felt you had to conceal your Parkinson's from people?	☐	☐	☐	☐	☐
24	Avoided situations which involve eating or drinking in public?	☐	☐	☐	☐	☐
25	Felt embarrassed in public due to having Parkinson's disease?	☐	☐	☐	☐	☐
26	Felt worried by other people's reaction to you?	☐	☐	☐	☐	☐
27	Had problems with your close personal relationships?	☐	☐	☐	☐	☐
28	Lacked support in the ways you need from your spouse or partner?	☐	☐	☐	☐	☐
	If you do not have a spouse or partner tick here		☐			
29	Lacked support in the ways you need from your family or close friends?	☐	☐	☐	☐	☐

*Please check that you have ticked **one box for each question** before going on to the next page*

Due to having Parkinson's disease, how often <u>during the last month</u> have you....		***Please tick <u>one</u> box for each question***				
		Never	**Occasionally**	**Sometimes**	**Often**	**Always**
30	Unexpectedly fallen asleep during the day?	☐	☐	☐	☐	☐
31	Had problems with your concentration, e.g. when reading or watching TV?	☐	☐	☐	☐	☐
32	Felt your memory was bad?	☐	☐	☐	☐	☐
33	Had distressing dreams or hallucinations?	☐	☐	☐	☐	☐
34	Had difficulty with your speech?	☐	☐	☐	☐	☐
35	Felt unable to communicate with people properly?	☐	☐	☐	☐	☐
36	Felt ignored by people?	☐	☐	☐	☐	☐
37	Had painful muscle cramps or spasms?	☐	☐	☐	☐	☐
38	Had aches and pains in your joints or body?	☐	☐	☐	☐	☐
39	Felt unpleasantly hot or cold?	☐	☐	☐	☐	☐

*Please check that you have ticked **one box for each question** before going on to the next page*

Thank you for completing the PDQ 39 questionnaire

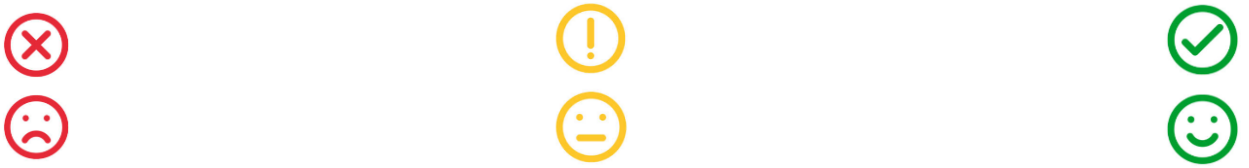
Activities-specific Balance Confidence Scale (ABC-S)

For each activity listed below, please indicate your level of confidence when performing it without losing your balance or becoming unsteady. Use a percentage scale between 0% (no confidence) to 100% (complete confidence).

No confidence in performing activity without losing balance write down 0% → Complete confidence in performing activity without losing balance write down 100%

If you have some confidence, then you will write down the percentage that you do feel confident

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



If you don't currently engage in the activity, try to imagine/estimate how confident you would feel if you had to do the activity. If you typically use a walking aid or hold onto someone while engaging in the activity, rate your confidence as if you were using those supports.

There are 16 activities to respond to.

1. Walking around the house? _____%
2. Walking up or down stairs? _____%
3. Bending over and pick up a slipper from the front of a closet floor? _____%
4. Reaching for a small can off a shelf at eye level? _____%
5. Standing on your tip toes and reach for something above your head? _____%
6. Standing on a chair and reach for something? _____%
7. Sweeping the floor? _____%
8. Walking outside the house to a car parked in the driveway? _____%

9. Getting into or out of a car? _____%
10. Walking across a parking lot to the mall? _____%
11. Walking up or down a ramp? _____%
12. Walking in a crowded mall where people rapidly walk past you? _____%
13. Being bumped into people as you walk through the mall? _____%
14. Stepping onto or off an escalator while you are holding onto a railing? _____%
15. Stepping onto or off an escalator while holding onto parcels so that you are not able hold onto the railing? _____%
16. Walking outside on icy sidewalks? _____%

Freezing of Gait Questionnaire (FOGQ)

1. **During your worst state—Do you walk:**

   0 Normally

   1 Almost normally—somewhat slow

   2 Slow but fully independent

   3 Need assistance or walking aid

   4 Unable to walk

2. **Are your gait difficulties affecting your daily activities and independence?**

   0 Not at all

   1 Mildly

   2 Moderately

   3 Severely

   4 Unable to walk

3. **Do you feel that your feet get glued to the floor while walking, making a turn or when trying to initiate walking (freezing)?**

   0 Never

   1 Very rarely—about once a month

   2 Rarely—about once a week

   3 Often—about once a day

   4 Always—whenever walking

4. **How long is your longest freezing episode?**

   0 Never happened

   1 1–2 s

   2 3–10 s

   3 11–30 s

   4 Unable to walk for more than 30 s

5. **How long is your typical start hesitation episode (freezing when initiating the first step)?**

   0 None

   1 Takes longer than 1 s to start walking

   2 Takes longer than 3 s to start walking

   3 Takes longer than 10 s to start walking

   4 Takes longer than 30 s to start walking

6. **How long is your typical turning hesitation: (freezing when turning)**

   0 None

   1 Resume turning in 1–2 s

   2 Resume turning in 3–10 s

   3 Resume turning in 11–30 s

   4 Unable to resume turning for more than 30 s

THANK YOU FOR PROVIDING THIS INFORMATION