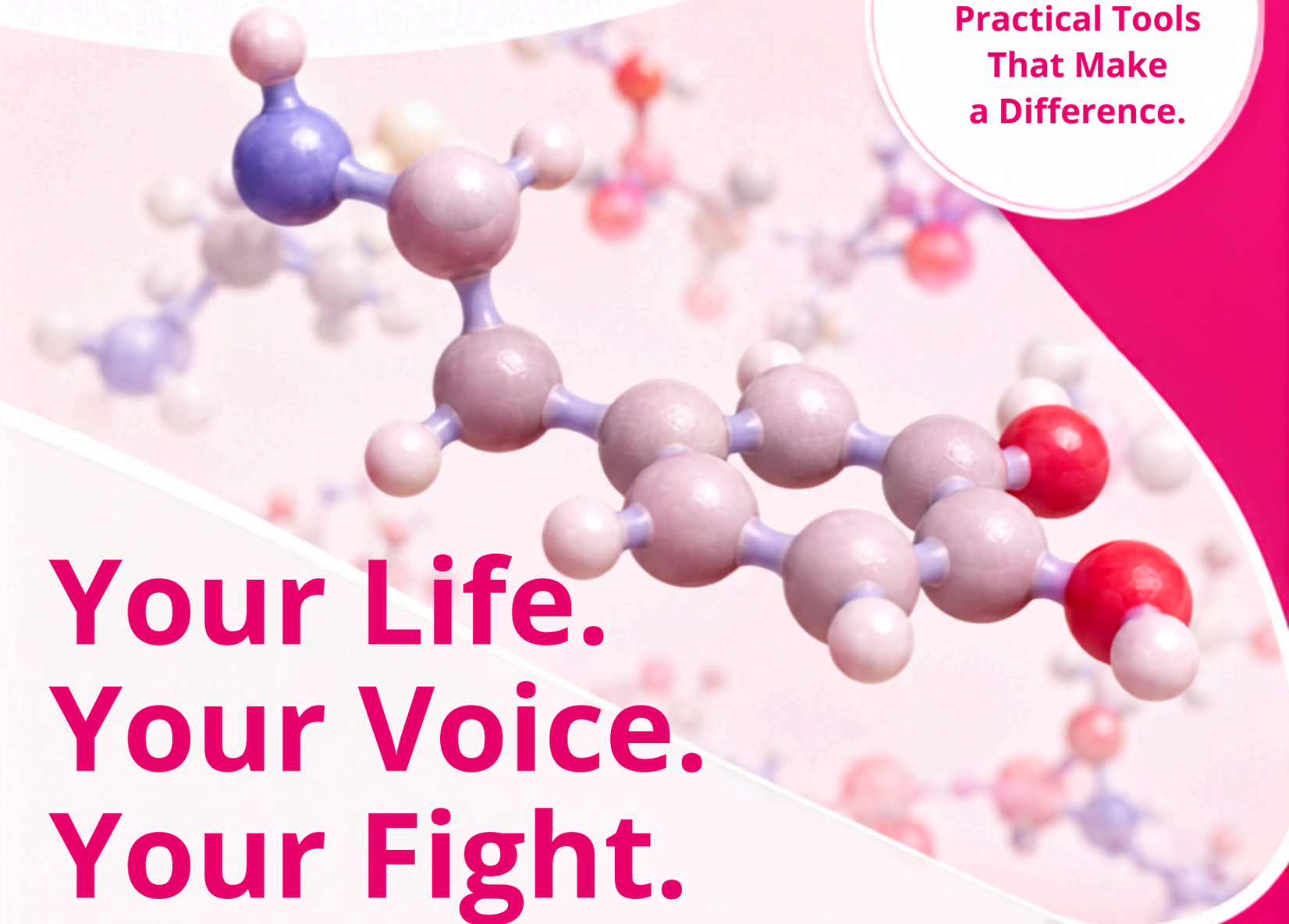
KILL PARKINSON

From Diagnosis to Daily Life — **Practical Tools That Make a Difference.**



Your Life. Your Voice. Your Fight.

The Essential Parkinson's Guide Printable Tools

English Edition

Author: Alexandra Robuste

Welcome to Your Essential PD Toolkit

Living with Parkinson's means keeping track of a lot — symptoms, medications, appointments, sleep, mood, energy, food. It's a lot to hold in your head. This toolkit is here to help.

These pages are yours. Print them, fill them in digitally, use one tracker or all of them — however they fit into your life. There is no right or wrong way. The goal is simply to make your days a little clearer, your appointments a little more productive, and your patterns a little easier to see.

Every tool in this kit was designed with real daily life in mind — not clinical perfection, but the kind of honest, practical tracking that actually helps you and your care team understand what's going on.

Use them today. Use them next month. Come back whenever you need a fresh page. You are not managing this alone. We are behind you — every step of the way.

Imprint

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⚠ *Medical Disclaimer — Please Read Before You Begin*

This guide/ trackers do not provide medical advice.
The information contained in this publication is intended for general informational and educational purposes only. It is not a substitute for professional medical advice, diagnosis, or treatment of any kind.

Never disregard professional medical advice or delay seeking it because of something you have read in this guide. Always consult your neurologist, physician, or a qualified healthcare provider before making any changes to your medication, therapy, diet, exercise routine, or any other aspect of your health management.

Parkinson's disease is a complex, individual condition. What works for one person may not work for another — and may even be harmful.

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Liability
Kill Parkinson gemeinnützige UG publishes this guide as part of its non-profit awareness mission. The purpose of this publication is to raise awareness about Parkinson's disease and make information more accessible to patients, caregivers, families, and the wider community. By making this information publicly available, we aim to support informed discussions with qualified healthcare professionals and promote greater understanding of the condition. This publication is intended solely for informational purposes and should not be interpreted as medical advice.

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Scientific Review
Melinda Barkhuizen, PhD

PERSONAL INFORMATION

For Medical & Emergency Use

PERSONAL DETAILS

Full Name: _____

Date of Birth: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Preferred Language: _____

MEDICAL ALERT

Diagnosis: _____

Year Diagnosed: _____

Medication timing is:

☐ Flexible ☐ **CRITICAL — must be on time**

Allergies: _____

Medications: _____

_____

Other (food, etc.): _____

_____

EMERGENCY CONTACTS

Primary Contact

Name: _____

Relationship: _____

Phone: _____

Secondary Contact

Name: _____

Relationship: _____

Phone: _____

Additional Contact (optional)

Name: _____

Relationship: _____

Phone: _____

MEDICATION SUMMARY

MEDICATION	DOSE	TIME(S) TAKEN

IMPORTANT NOTE

Do not delay or skip Parkinson's medication.
Even short delays can cause serious complications.

PHARMACY

Pharmacy Name: _____

Phone: _____

Address: _____

_____

_____

DOCTORS & CARE TEAM

Neurologist / Movement Disorder Specialist

Name: _____

Clinic / Hospital: _____

Phone: _____

Email (optional): _____

Primary Care Physician

Name: _____

Phone: _____

Clinic: _____

Other Specialists (if any)

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

PARKINSON'S OVERVIEW

Typical OFF Symptoms:

_____

_____

_____

Known Triggers (if any):

_____

_____

_____

Symptoms / Issues (check all that apply):

☐ Dyskinesia ☐ Freezing ☐ Tremor

☐ Rigidity ☐ Balance Issues ☐ Fall Risk

☐ Swallowing Issues ☐ Orthostatic Hypotension

Other Notes:

_____

_____

_____

MEDICAL DEVICES

☐ Deep Brain Stimulator (DBS)
Device Card Location: _____

☐ Other Device: _____

Notes: _____

_____

_____

INSURANCE INFORMATION

Insurance Provider: _____

Policy Number: _____

Group Number (if any): _____

Customer Service / Emergency Number: _____

_____

IN CASE OF EMERGENCY

Preferred Hospital: _____

Preferred ER (if known): _____

Notes for Medical Staff:

_____

_____

_____

_____

ADVANCE DIRECTIVES

Healthcare Proxy (Name): _____

Relationship: _____

Phone: _____

Living Will / Advance Directive: ☐ Yes ☐ No

Location / Notes: _____

Power of Attorney: ☐ Yes ☐ No

Location / Notes: _____

ADDITIONAL NOTES

_____

_____

_____

_____

PART 8

MEDICATION PLAN & TRACKER – DAILY

DATE: _____

Stay on time. Stay in balance. Track your medications and how they work for you.

MON TUE WED THU FRI SAT SUN

1. DAILY MEDICATION SCHEDULE

TIME (e.g. 7:00 AM)	MEDICATION NAME (Brand / Generic)	DOSE (mg, mcg, etc.)	HOW TAKEN (1 tab, 1 cap, etc.)	WITH / WITHOUT FOOD	PLANNED TIME	ACTUAL TIME TAKEN	NOTES (e.g. with protein)
6:00 AM							
9:00 AM							
12:00 PM							
3:00 PM							
6:00 PM							
9:00 PM							
12:00 AM							
3:00 AM							
_____							

2. MEDICATION EFFECT TRACKER (For each main medication dose)

TIME TAKEN	MEDICATION (Name)	DOSE	KICKED IN (Time)	WORKING WELL? (1–5)	PEAK EFFECT (Time)	START WEARING OFF (Time)	WORE OFF (Time)	NOTES
				1 2 3 4 5				
				1 2 3 4 5				
				1 2 3 4 5				
				1 2 3 4 5				
				1 2 3 4 5				

3. SIDE EFFECTS TRACKER

TIME	MEDICATION (Name)	SIDE EFFECT (What happened?)	SEVERITY (1–5)	HOW LONG DID IT LAST?	WHAT HELPED?	NOTES

4. OTHER MEDICATIONS & SUPPLEMENTS (Daily)

TIME	MEDICATION / SUPPLEMENT (Name)	DOSE	REASON (Why taking)	NOTES

Set reminders. Use alarms. Stay consistent.

PART 8

MEDICATION PLAN & REVIEW – WEEKLY

WEEK OF: _____

1. WEEKLY OVERVIEW

Did you take your medications as prescribed this week?
☐ Yes ☐ No
If no, why? _____

How was your overall medication effectiveness this week?
(1 = poor 5 = excellent)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Any changes in symptoms or side effects?
☐ Yes ☐ No
If yes, describe: _____

Any missed doses?
☐ Yes ☐ No
If yes, how many? _____
When? _____

Anything you want to discuss with your doctor?
_____
_____
_____

2. MEDICATION SUMMARY (Weekly)

MEDICATION NAME (Brand / Generic)	DOSE	HOW OFTEN (Times per day)	BEST TIME OF DAY (for you)	WORKING WELL? (1–5)	SIDE EFFECTS? (Y / N)	NOTES / CHANGES THIS WEEK
				1 2 3 4 5		
				1 2 3 4 5		
				1 2 3 4 5		
				1 2 3 4 5		
				1 2 3 4 5		
				1 2 3 4 5		

3. SIDE EFFECTS SUMMARY (Weekly)

SIDE EFFECT	HOW OFTEN THIS WEEK? (Rare / Sometimes / Often)	SEVERITY (1–5)	TREND (Better / Same / Worse)	NOTES

4. WHAT HELPED THIS WEEK?

- ☐ Medications working well
- ☐ Adjusted timing
- ☐ Adjusted diet / protein timing
- ☐ Exercise / movement
- ☐ Hydration
- ☐ Sleep
- ☐ Stress management
- ☐ Other: _____

5. WHAT WAS CHALLENGING?

- ☐ Wearing off too early
- ☐ Delayed "on" time
- ☐ Side effects
- ☐ Remembering doses
- ☐ Complex schedule
- ☐ Cost / access
- ☐ Other: _____

6. QUESTIONS / NOTES FOR MY DOCTOR

_____
_____
_____
_____
_____
_____

7. PLAN FOR NEXT WEEK

What do I want to continue? _____
_____
What do I want to improve? _____
_____
What will I try? _____
_____

★ Your consistency helps your care team help you better.

Bring this to every appointment.

MEDICATION RESPONSE TRACKER – DAILY

Precision matters. Timing is treatment.

DATE: _____

MON TUE WED THU FRI SAT SUN

MEDICATION / DOSE: _____ STRENGTH: _____

1 DOSE TIMING

Exact time each dose is taken.

TIME DOSE TAKEN: : ☐ AM ☐ PM

NOTES (if any):

2 "ON" RESPONSE

When medication starts working.

TIME "ON" BEGINS: : ☐ AM ☐ PM

DELAY (APPROX.): _____ min

WHAT I NOTICE WHEN IT "KICKS IN":

3 "OFF" PERIODS

When medication wears off.

TIME "OFF" BEGINS: : ☐ AM ☐ PM

SYMPTOMS RETURNING / WORSENING:

WHAT I NOTICE WHEN IT WEARS OFF:

4 DURATION

How long each dose lasts.

START OF EFFECT (ON): : ☐ AM ☐ PM

END OF EFFECT (OFF): : ☐ AM ☐ PM

TOTAL DURATION: _____ hrs

5 DYSKINESIA

Track when it occurs, how severe it is, and its impact.

WHEN DID IT occur?

(TIME / PERIOD):

SEVERITY: Mild ☐ Moderate ☐ Severe ☐

IMPACT ON DAILY FUNCTION:
- ☐ No impact
- ☐ Mild impact
- ☐ Moderate impact
- ☐ Severe impact

NOTES / DETAILS:

6 OVERALL MEDICATION EFFECT

How well did medication work today?

OVERALL RATING:
(1 = Very poor 5 = Excellent)

1 2 3 4 5

NOTES / PATTERNS / ANYTHING IMPORTANT:

OTHER FACTORS THAT MAY HAVE INFLUENCED TODAY

(Check all that apply)

- ☐ Poor sleep
- ☐ Stress
- ☐ Illness
- ☐ High activity
- ☐ Low activity
- ☐ Diet changes
- ☐ Dehydration
- ☐ Weather
- ☐ Other: _____

ANYTHING ELSE TO NOTE?

Track the details. See the patterns.

Patterns guide adjustments. You guide your care.

Small logs. Big impact.

PART 8

NOTES

CAPTURE. CLARIFY. MOVE FORWARD.

DATE: _____ DAY: _____ WEEK: _____

NOTES & THOUGHTS

WHAT STOOD OUT TODAY?

ANY SYMPTOM CHANGES?

ANYTHING UNUSUAL?

POSSIBLE TRIGGERS
(STRESS, SLEEP, FOOD, ETC.)

WHAT HELPED?

FOR MY DOCTOR
QUESTIONS / THINGS TO MENTION

FOLLOW-UP / ACTIONS
WHAT I WANT TO TRY OR CHANGE

SMALL DETAILS MATTER. | PATTERNS START HERE.