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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Author
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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

HYDRATION TRACKER – DAILY

DATE: _____

Hydration fuels your body, supports your brain, and helps your meds work better.

MON TUE WED THU FRI SAT SUN

1. DAILY HYDRATION GOAL

Daily fluid goal:

_____ ml

(or _____ glasses)

Today's focus:

- ☐ Stay consistent
- ☐ Spread evenly
- ☐ Drink earlier in the day
- ☐ Other: _____

How would you rate your hydration today?

1 (Very low) 5 (Excellent)

Did you meet your goal?

- ☐ Yes
- ☐ Mostly
- ☐ No

If no, by how much? _____

2. FLUID INTAKE LOG

TIME	WHAT I DRANK	AMOUNT (ml / oz / cups)	GLASSES (✓)	HOW IT MADE ME FEEL (1–5)	NOTES
6 AM – 9 AM				1 2 3 4 5	
9 AM – 12 PM				1 2 3 4 5	
12 PM – 3 PM				1 2 3 4 5	
3 PM – 6 PM				1 2 3 4 5	
6 PM – 9 PM				1 2 3 4 5	
9 PM – Bedtime				1 2 3 4 5	
TOTAL		_____ ml	_____ glasses	Average: _____ / 5	

3. HYDRATION QUALITY

What was most of your fluid today?

- ☐ Water
- ☐ Sparkling water
- ☐ Tea / Herbal tea
- ☐ Coffee
- ☐ Milk / Plant milk
- ☐ Juice
- ☐ Electrolyte drink
- ☐ Other: _____

How would you rate the quality of your choices?
fluid choice:

1 (Poor) 5 (Excellent)

4. TIMING CHECK

Did you spread your fluids evenly?

- ☐ Yes
- ☐ Afternoon
- ☐ No

Did you drink enough earlier in the day?

- ☐ Yes
- ☐ Afternoon
- ☐ Night

Most of my fluids were: ☐ Morning ☐ Evening / Night

5. HOW DID MY HYDRATION AFFECT ME TODAY? (Rate 1–5)

Energy Level	Focus / Mental Clarity	Headaches	Dizziness / Lightheaded	Constipation / Digestion	Urination (Comfort)
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

Notes / Patterns:

6. HYDRATION CHALLENGES

What got in the way today?

- ☐ Forgot
- ☐ Too busy
- ☐ Not thirsty
- ☐ Bathroom concerns
- ☐ Wasn't accessible
- ☐ Other: _____

How can I make it easier tomorrow?

7. NOTES & REFLECTION

What worked well today?

What will I do differently tomorrow?

Anything I want to share with my doctor?

Small sips. Consistent habits. Big impact.

Hydrated today. Stronger tomorrow.

PART 8

NUTRITION TRACKER – DAILY

DATE: _____

Fuel your body. Support your brain. Optimize your day.

MON TUE WED THU FRI SAT SUN

1. TODAY'S NUTRITION GOALS

My goals for today:

- _____
- _____
- _____

Focus for today:

- ☐ More protein
- ☐ Better timing
- ☐ Hydration
- ☐ Fiber / Digestion
- ☐ Weight / Energy
- ☐ Other: _____

How did I fuel myself today?

(1 = Poor 3 = Okay 5 = Excellent)

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

2. MEALS & SNACKS

TIME	MEAL / SNACK	WHAT I ATE & DRANK (Be as specific as you can)	PROTEIN (g)	CARBS (g)	FAT (g)	FIBER (g)	CALORIES (approx.)	NOTES (Hunger? Fullness? Cravings?)
BREAKFAST								
LUNCH								
DINNER								
SNACKS / OTHERS								
DAILY TOTAL (approx.)		_____ g	_____ g	_____ g	_____ g		_____ kcal	

3. PROTEIN TIMING (Important for medication effectiveness)

MORNING (6 AM – 12 PM)
Protein: ☐ Yes ☐ No
Amount: _____ g

AFTERNOON (12 PM – 6 PM)
Protein: ☐ Yes ☐ No
Amount: _____ g

EVENING (6 PM – 9 PM)
Protein: ☐ Yes ☐ No
Amount: _____ g

NIGHT (9 PM – Bedtime)
Protein: ☐ Yes ☐ No
Amount: _____ g

Protein timing today was: ☐ Good ☐ Okay ☐ Not ideal Why? _____

4. HYDRATION (Glasses / ml)

Total today: _____ glasses / _____ ml

Water quality: ☐ Poor ☐ Okay ☐ Good ☐ Great

5. HUNGER & FULLNESS

How hungry was I before meals?
(1 = Not hungry 5 = Very hungry)
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

How full was I after meals?
(1 = Not full 5 = Overly full)
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

★ Good nutrition + good timing = better energy, better movement, better days.

PART 8

6. NUTRIENT QUALITY CHECK (Check all that apply)

PROTEIN	FIBER & PLANTS	HEALTHY FATS	MICRONUTRIENTS	ULTRA-PROCESSED FOODS
☐ Adequate protein	☐ 5+ servings fruits/veggies	☐ Omega-3 sources	☐ Colorful plate	☐ Minimal / None
☐ High-quality sources	☐ Good fiber intake	☐ Nuts / Seeds	☐ Variety of foods	☐ Some
☐ Spread throughout day	☐ Fermented foods	☐ Olive oil / Avocado	☐ Greens / Leafy veg	☐ More than usual
☐ Low today	☐ Low fiber today	☐ Low healthy fats	☐ Low variety	☐ Too much today
☐ Other: _____	☐ Other: _____	☐ Other: _____	☐ Other: _____	☐ Other: _____

7. WHAT MAY HAVE AFFECTED MY NUTRITION TODAY?

☐ Stress ☐ Busy day ☐ Poor sleep ☐ Low energy ☐ Emotional eating ☐ Social events

☐ Travel ☐ Not hungry ☐ Appetite changes ☐ Digestive issues ☐ Cravings ☐ Other: _____

Details: _____

8. DIGESTION & GUT

Digestion today:

☐ Great
☐ Good
☐ Poor
☐ Very poor

Any digestive issues?

☐ Yes ☐ No

If yes, what? _____

Bowel movement today?

☐ Yes (normal)
☐ Yes (not normal)
☐ No

Notes: _____

9. CRAVINGS & SATISFACTION

Did I have cravings today?

☐ Yes ☐ No

What did I crave? _____

Did I satisfy the cravings?

☐ Yes ☐ No ☐ Partly

How satisfied was I with my food choices today?
(1 = Not at all 5 = Very satisfied)

1 ○ 2 ○ 3 ○ 4 ○ 5 ○

What helped me make good choices today?

_____
_____
_____

What made it challenging?

_____
_____
_____

10. NOTES & REFLECTION

What went well with my nutrition today?	What will I do differently tomorrow?	One key thing I want to focus on:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Small choices today create big changes tomorrow. **Consistent > Perfect**

PART 8

NUTRITION & PROTEIN TRACKER – DAILY

Good nutrition. Smart timing. Better symptom control.

DATE: _____

MON TUE WED THU FRI SAT SUN

1. DAILY NUTRITION GOALS

- ☐ Eat balanced meals
- ☐ Stay hydrated
- ☐ Get enough protein
- ☐ Eat enough fiber
- ☐ Time protein around meds
- ☐ Reduce sugar / ultra-processed

Today's focus: _____

_____

Did you meet your goals?

- ☐ Yes
- ☐ Mostly
- ☐ No

2. MEALS & SNACKS LOG

TIME	MEAL / SNACK	WHAT I ATE / DRANK (Details)	PROTEIN (g)	CARBS (g)	FAT (g)	FIBER (g)	PROTEIN TIMING (Relative to Meds)			HOW I FELT AFTER (1–5)
							Before	With	After	
Breakfast							☐	☐	☐	1 2 3 4 5
Snack							☐	☐	☐	1 2 3 4 5
Lunch							☐	☐	☐	1 2 3 4 5
Snack							☐	☐	☐	1 2 3 4 5
Dinner							☐	☐	☐	1 2 3 4 5
Evening Snack							☐	☐	☐	1 2 3 4 5
DAILY TOTAL										Average: _____ / 5

3. PROTEIN TIMING CHECK

Did you space protein away from your medication?

- ☐ Yes (Good timing)
- ☐ Somewhat
- ☐ No (Too close)

Notes / What I noticed: _____

4. NUTRITION QUALITY

How would you rate the quality of your nutrition today?

☆ ☆ ☆ ☆ ☆

1 (Poor) 5 (Excellent)

How balanced were your meals?

- ☐ Poor
- ☐ Fair
- ☐ Gain
- ☐ Pair
- ☐ Very Good
- ☐ Excellent

Notes: _____

5. HOW DID MY NUTRITION AFFECT ME TODAY? (Rate 1–5)

Energy Level	Focus / Mental Clarity	Blood Sugar Stability
1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Digestive Comfort	Mood / Emotional Well-Being	Motor Symptoms (Overall Impact)
1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Notes / Patterns: _____

6. NUTRITION CHALLENGES

What got in the way today?

- ☐ Not enough time
- ☐ Low appetite
- ☐ Travel / Out
- ☐ Cravings
- ☐ Digestive issues
- ☐ Other: _____

How will I improve tomorrow?

_____

7. NOTES & REFLECTION

What worked well today?

_____

What will I do differently tomorrow?

_____

Anything I want to share with my doctor?

_____

Nourish your body. Time your protein. Support your movement.

PART 8

WEIGHT TRACKER – DAILY

DATE: _____

Track the trend. Not just the number.

MON TUE WED THU FRI SAT SUN

1. TODAY'S WEIGHT

Today's weight

_____ kg

_____ lbs

Time of day

- ☐ Morning (after bathroom)
- ☐ Evening
- ☐ Other: _____

How does this compare?

Compared to yesterday

☐ Lower ☐ Same ☐ Higher

Compared to last week

☐ Lower ☐ Same ☐ Higher

2. WEIGHT TREND LOG

DATE	WEIGHT (kg)	WEIGHT (lbs)	TIME OF DAY	CHANGE (vs. yesterday)	NOTES (e.g., clothing, bloating, illness)
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	

3. WEEKLY SUMMARY

Average weight this week

_____ kg

_____ lbs

Lowest weight

_____ kg

Date: _____

Highest weight

_____ kg

Date: _____

Weight change this week

_____ kg

☐ Gain ☐ Loss ☐ No change

4. FACTORS THAT MAY HAVE AFFECTED MY WEIGHT THIS WEEK (Check all that apply)

- ☐ Diet / Calorie intake
- ☐ Protein intake
- ☐ Hydration
- ☐ Exercise / Activity
- ☐ Constipation / Bowel changes
- ☐ Sleep quality
- ☐ Stress
- ☐ Illness / Infection
- ☐ Medication changes
- ☐ Fluid retention / Bloating
- ☐ Alcohol
- ☐ Other: _____

5. NOTES & REFLECTION

What worked well this week?

_____

_____

_____

What will I do differently next week?

_____

_____

_____

Anything to share with my doctor?

_____

_____

_____

★ Focus on progress, not perfection. Small changes lead to big results.

PART 8

WEIGHT TRACKER – MONTHLY

Track the trend. Not the noise.

MONTH: _____ YEAR: _____

STARTING WEIGHT	CURRENT WEIGHT	CHANGE THIS MONTH
_____ kg / lbs	_____ kg / lbs	↓ ☐ → ☐ ↑ ☐ _____ kg / lbs

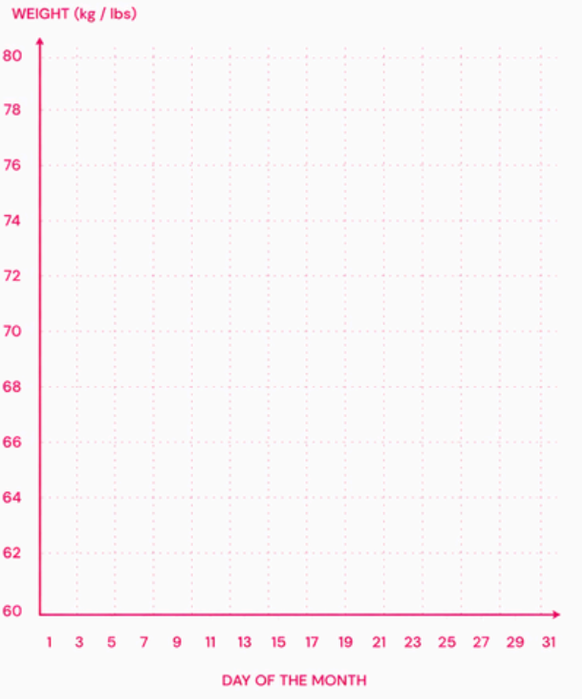
1. WEIGHT LOG

Log your weight when it makes sense for you.

DATE	WEIGHT (kg / lbs)	TIME (AM / PM)	NOTES (anything relevant)
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	
__/__		☐ AM ☐ PM	

2. WEIGHT TREND

Connect your data points to see the trend.



3. WHAT MAY HAVE INFLUENCED MY WEIGHT?

- ☐ Appetite changes
- ☐ Activity level
- ☐ Hormonal changes
- ☐ Medication effects
- ☐ Illness / infection
- ☐ Travel / routine change
- ☐ Constipation / digestion
- ☐ Sleep
- ☐ Other: _____
- ☐ Fluid retention / bloating
- ☐ Stress

4. BODY SIGNALS

ENERGY LEVEL

☹ Low ☐ 😐 Medium ☐ ☺ High ☐

APPETITE

☹ Low ☐ 😐 Normal ☐ ☺ High ☐

5. NOTES & PATTERNS

What do I notice about my weight this month?

6. FOR MY DOCTOR

Anything relevant to mention?

Focus on progress, not perfection.

Trends tell the story. Consistency reveals the pattern.

Small changes. Big impact.

BOWEL TRACKER – DAILY

matters. Your comfort matters.

DATE: ____________________

MON TUE WED THU FRI SAT SUN

1. BOWEL MOVEMENT LOG

DATE	TIME (e.g., 8:00 AM)	TYPE (Bristol Stool Scale)	EFFORT (1 = Easy, 5 = Very hard)	COMPLETE EVACUATION?	FEELING AFTER	NOTES / TRIGGERS
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ 😐 ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ 😐 ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ 😐 ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ 😐 ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ 😐 ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ 😐 ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ 😐 ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ 😐 ☹	

2. BRISTOL STOOL SCALE GUIDE

1		Separate hard lumps, like nuts (hard to pass)
2		Sausage-shaped but lumpy
3		Like a sausage or snake, with cracks on the surface
4		Like a sausage or snake, smooth and soft
5	(soft blobs)	Soft blobs with clear-cut edges (easy to pass)
6	(mushy)	Fluffy pieces with ragged edges, mushy
7	(watery)	Watery, no solid pieces, entirely liquid

3. TODAY'S BOWEL SUMMARY

Did you have a bowel movement today? ☐ Yes ☐ No

How would you rate your overall bowel comfort today?

1 2 3 4 5

(1 = Very uncomfortable 5 = Very comfortable)

Any bloating or gas?

☐ None ☐ Mild ☐ Moderate ☐ Severe

Any pain or cramping?

☐ None ☐ Mild ☐ Moderate ☐ Severe

Comments: ____________________

4. SUPPORTS & STRATEGIES (Check all that apply)

- ☐ Water / Fluids
- ☐ High fiber foods
- ☐ Fruits
- ☐ Vegetables
- ☐ Prunes / Raisins
- ☐ Whole grains
- ☐ Probiotics
- ☐ Magnesium
- ☐ Stool softener
- ☐ Laxative
- ☐ Fiber supplement
- ☐ Other: __________

Other things that helped: ____________________

5. NOTES & PATTERNS

What seems to help mesy regular? ____________________

What makes constipation worse? ____________________

Anything to tell my doctor? ____________________

Listening to your body helps you stay ahead. You are in control.

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.