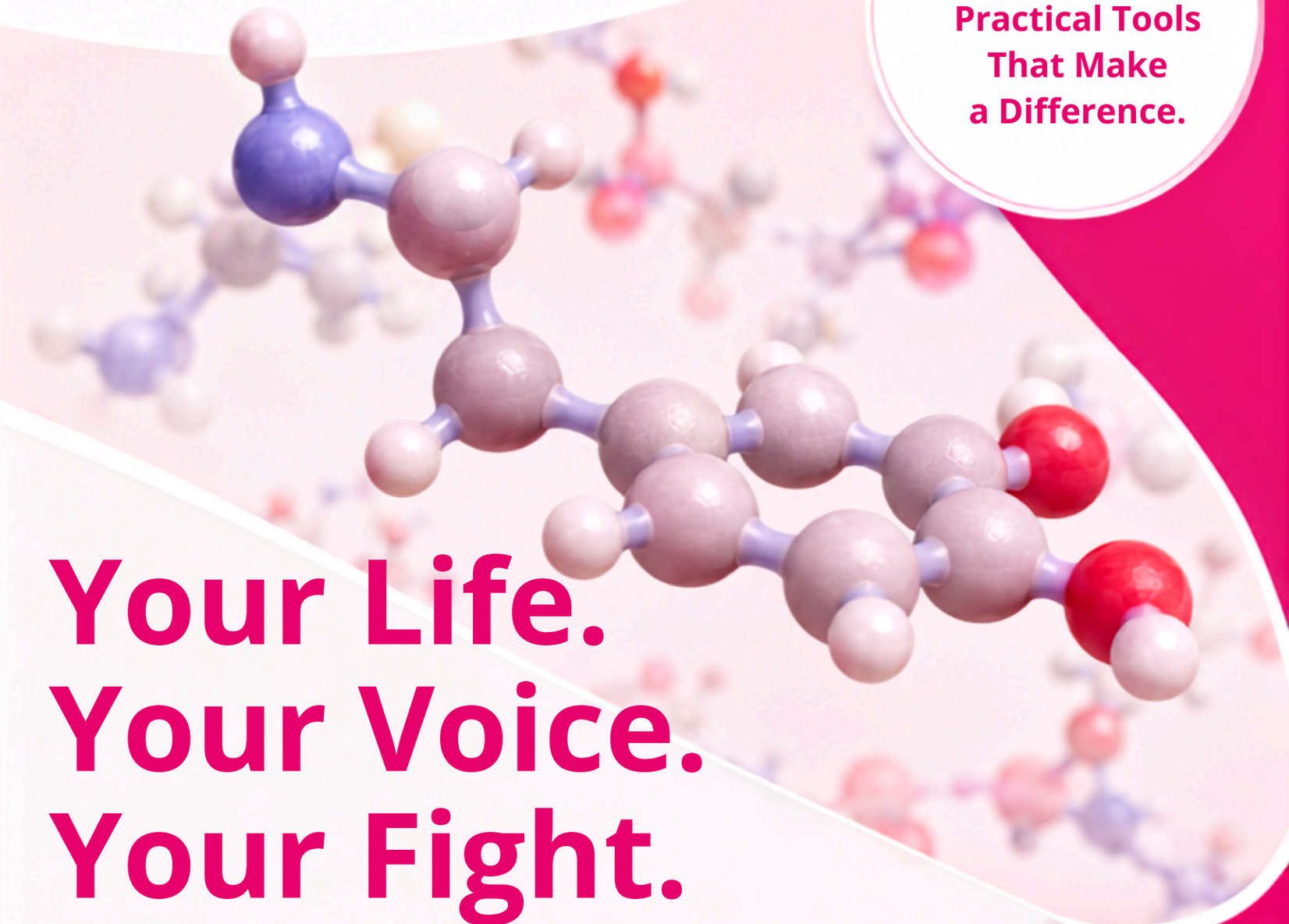
KILL PARKINSON

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

SLEEP TRACKER

Track your sleep. Understand your patterns.

DATE: _____

NIGHT OVERVIEW

Time I went to bed: _____	Time lights out: _____	Time I woke up: _____	Hours slept: _____
Sleep quality: ☐ Poor ☐ Fair ☐ Good ☐ Great		Night disturbances (summary): _____	

SLEEP LOG – NIGHT TIME (Check all that apply for each time block)

TIME	ASLEEP	AWAKE	WOKE UP (Briefly)	WOKE UP (> 5 min)	BATHROOM	PAIN / DISCOMFORT	RLS / RESTLESS	NIGHT SWEATS	TROUBLE BREATHING	OTHER (Notes)
8:00 PM – 9:00 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
9:00 PM – 10:00 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
10:00 PM – 11:00 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
11:00 PM – 12:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
12:00 AM – 1:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
1:00 AM – 2:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
2:00 AM – 3:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
3:00 AM – 4:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
4:00 AM – 5:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
5:00 AM – 6:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
6:00 AM – 7:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
7:00 AM – 8:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____

EVENING / BEDTIME ROUTINE (Check all that apply)

- ☐ Exercise
- ☐ Screen time
- ☐ Alcohol
- ☐ Stretching / Yoga
- ☐ Reading
- ☐ Caffeine
- ☐ Meditation / Breathing
- ☐ Music
- ☐ Heavy meal late
- ☐ Hot shower / bath
- ☐ No routine
- ☐ Other: _____

NOTES ABOUT THE NIGHT

_____

_____

_____

_____

_____

_____

PART 8

MORNING & DAYTIME SUMMARY

Morning stiffness: ☐ None ☐ Mild ☐ Moderate ☐ Severe Duration: _____

First medication: _____

Time taken: _____

Kicked in at: _____

Mood on waking (1–5): _____

Energy level (1–5): _____

Bowel movement: ☐ Yes ☐ No

Notes: _____

DAYTIME NAPS

Did you nap today? ☐ Yes ☐ No

If yes, please log below.

NAP START TIME	NAP END TIME	DURATION	REFRESHED? (Yes / No)	NOTES
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

FACTORS THAT MAY HAVE AFFECTED SLEEP

- ☐ Stress / Anxiety
- ☐ Illness / Infection
- ☐ Pain
- ☐ Medication change
- ☐ Too much caffeine
- ☐ Alcohol
- ☐ Late meal
- ☐ Travel / Time change
- ☐ Weather / Temperature
- ☐ Other: _____

SYMPTOMS IMPACTING SLEEP (Check all that apply)

- ☐ Tremor
- ☐ Stiffness
- ☐ Pain
- ☐ Restless legs
- ☐ Anxiety
- ☐ Urinary frequency
- ☐ Reflux / Heartburn
- ☐ Dream enactment
- ☐ Hallucinations
- ☐ Depression
- ☐ Other: _____

MEDICATION NOTES

Any medication taken at night or during the night?

_____

_____

_____

HOW DID YOUR SLEEP AFFECT YOUR DAY?

☐ Positively ☐ Neutral ☐ Negatively Notes: _____

NOTES / OBSERVATIONS

_____

_____

WEEKLY PATTERN SUMMARY (Optional – Look back at the week)

Best nights: _____

Worst nights: _____

What seems to help: _____

What seems to make it worse: _____

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.