

# Weekly Survey Form for the Formula #12 Trial

Week #: \_\_\_\_\_ Date: \_\_\_\_\_

We wish to monitor any changes in your health status while taking Formula #12. Please answer the following:

## 1. During the past week, have you experienced any of the following:

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| a. added constipation?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| b. added diarrhea?.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| c. sleeping problems?.....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. any negative changes in your complexion or any rashes?.. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. any negative changes in your breathing?.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| f. any negative digestive changes?.....                     | <input type="checkbox"/> | <input type="checkbox"/> |

## 2. This product seems to be causing me the following discomforts (if any) not listed above:

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## 3. Assessment of symptoms of your Parkinson's Disease:

For each symptom you had when the trial began, use the two scales below to estimate the current level of severity and any perceived changes [plus or minus] since the trial began.

### Current Level of Severity

( 0 ..... 1 ..... 2 ..... 3 ..... 4 )  
 | | | | |  
 not infrequent some bad very  
 a problem problems problems bad bad

### Any Perceived Changes in Severity Since Trial Began

(-2 ..... -1 ..... 0 ..... +1 ..... +2)  
 | | | | |  
 much worse no somewhat much  
 worse change improved improved

#### Severity

#### Changes in Severity [plus or minus since trial began]

<input type="checkbox"/> Tremors in hands and/or legs	---	---
<input type="checkbox"/> Mobility problems	---	---
<input type="checkbox"/> Stiffness or weakness	---	---

<input type="checkbox"/> Speech difficulties	---	---
<input type="checkbox"/> Rigid facial expression	---	---
<input type="checkbox"/> Weak voice	---	---

<input type="checkbox"/> Heavy and/or rigid extremities	---	---
<input type="checkbox"/> Slower movements	---	---
<input type="checkbox"/> Difficulty with posture	---	---

<input type="checkbox"/> Balance difficulties	---	---
<input type="checkbox"/> Difficulty with daily activities	---	---
<input type="checkbox"/> Constipation	---	---

<input type="checkbox"/> Fatigue	---	---
<input type="checkbox"/> Chewing or eating difficulties	---	---
<input type="checkbox"/> Confusion or befuddled	---	---

<input type="checkbox"/> Hallucinations	---	---
<input type="checkbox"/> Other: _____	---	---
<input type="checkbox"/> Other: _____	---	---

Participant's Name \_\_\_\_\_  
 [Print name]

\_\_\_\_\_  
 [signature]