BUDDY PROGRAM QUESTIONAIRE

NAME:

ADDRESS:

CITY/STATE/ZIP:

PHONE NUMBER:

EMAIL:

DATE OF BIRTH:

GENDER: Male/Female

HOW LONG HAVE YOU BEEN DIAGNOSED WITH PARKINSON'S?

NAME OF YOUR DOCTOR/CONTACT INFORMATION?

SYMPTOMS:

CURRENT MEDICATIONS:

INTERESTS/HOBBIES:

WHAT ARE YOU LOOKING TO GAIN FROM THIS EXPERIENCE?

DO YOU HAVE A WAY TO GET AROUND AND RELIABLE TRANSPORTATION (i.e. do you drive or have a caregiver that can drive you)?

HOW MUCH TIME PER MONTH ARE YOU ABLE TO DEDICATE TO THIS PROGRAM (expectation is 3-4 hours per month)?

EMERGENCY CONTACT INFORMATION

NAME:

ADDRESS:

PHONE NUMBER:

I agree and understand that the medical students in this program are not licensed health professional and I will not rely on any medical advice they give me. I, for myself, my heirs, executors, and administrators waive, hold harmless and release any and all rights and claims for damages I may now or hereafter have or allege against Parkinson Support Center, University of Louisville Medical School or University of Louisville Physicians and assigns for any injury I may incur while participating in the program. I assume all risks associate with my participation in the program.

_____ _____

Participants Signature **Participants Printed Name**

_____

Date