

INSIGHT Institute for Neurodegenerative Research

Neurological Health, Gut, Skin, Eye, Sinus & Environmental Questionnaire

Purpose: This questionnaire is designed to help INSIGHT identify potential patterns involving neurological symptoms, gastrointestinal health, skin and eye conditions, sinus problems, exercise, and environmental exposures. The information will help guide future research and testing priorities.

Participation is voluntary. Please answer as many questions as possible. Please review the consent and privacy information at the end of this questionnaire.

Participant: _____

Date: _____

Completed by:

- ☐ Participant
- ☐ Caregiver or family member
- ☐ Participant with caregiver assistance

Section 1: Diagnosis and Neurological Symptoms

1. Have you been diagnosed with any of the following conditions? (Check all that apply.)

- ☐ Parkinson's disease (PD)
- ☐ Dementia with Lewy bodies (DLB)
- ☐ Parkinson's disease dementia (PDD)
- ☐ Multiple system atrophy (MSA)
- ☐ Another neurological disease
- ☐ Another medical condition
- ☐ Healthy control (no diagnosed neurological disease)
- ☐ Undiagnosed or currently undergoing evaluation

If another condition, please specify:

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2. Approximately when did your neurological symptoms begin, and when were you diagnosed (if applicable)?

Symptom onset: _____

Year diagnosed: _____

3. How have your neurological symptoms changed over the past six months?

- ☐ Improving
- ☐ Stable
- ☐ Worsening
- ☐ Fluctuating between improvement and worsening
- ☐ Not applicable (control participant)

4. What do you believe may be contributing to your symptoms improving, worsening, or remaining stable?

Consider medications, exercise, diet, sleep, infections, environmental changes, treatments, or other factors.

Section 2: Gastrointestinal Health and Gut Microbiome

5. Did you experience gastrointestinal (gut) problems before your neurological symptoms or diagnosis?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Not applicable

If yes, please describe the symptoms and approximately when they began.

6. Do you currently experience gastrointestinal problems?

- ☐ Yes
- ☐ No
- ☐ Occasionally

If yes, which symptoms do you experience? (Check all that apply.)

- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating or excessive gas
- ☐ Abdominal pain
- ☐ Acid reflux
- ☐ Food intolerances
- ☐ Other: _____

7. Do you notice worsening neurological symptoms when you experience gastrointestinal problems?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Unsure
- ☐ Not applicable

If yes, which neurological symptoms become worse?

8. Have dietary changes, probiotics, medications, or other treatments improved or worsened your gut symptoms or neurological symptoms?

- ☐ Yes, improved
- ☐ Yes, worsened
- ☐ No noticeable change
- ☐ Unsure
- ☐ Not applicable

Please explain:

9. Would you be interested in participating in gut microbiome testing?

- ☐ Yes
- ☐ No
- ☐ Maybe — I would like additional information

Section 3: Exercise and Symptom Changes

10. Do you exercise regularly?

- ☐ Daily
- ☐ Several times per week
- ☐ Occasionally
- ☐ Rarely or never

If yes, what types of exercise do you participate in?

11. Have you noticed improvements in your gastrointestinal symptoms following exercise?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Unsure
- ☐ Not applicable

Please explain:

12. Have you noticed improvements in neurological symptoms following exercise?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Unsure
- ☐ Not applicable

If yes, which symptoms improve, and approximately how long does the improvement last?

Section 4: Skin and Eye Health

13. Did you experience skin or eye problems before the onset of your neurological symptoms or diagnosis?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Not applicable

If yes, please describe these conditions and when they began.

14. Do you currently experience skin or eye problems?

- ☐ Yes
- ☐ No
- ☐ Occasionally

If yes, please indicate which conditions or symptoms apply.

- ☐ Dry, itchy, or irritated skin
- ☐ Unexplained rashes or sores
- ☐ Rosacea or facial redness
- ☐ Flaky skin or excessive skin debris
- ☐ Itchy, irritated, or inflamed eyes
- ☐ Blepharitis (eyelid inflammation)
- ☐ Dry eyes
- ☐ Recurrent eye infections or irritation
- ☐ Other: _____

15. Have you noticed a relationship between your skin or eye symptoms and changes in your neurological symptoms?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Not applicable

Please explain:

Section 5: Sinus, Nasal and Eye-Area Symptoms

16. Do you currently experience, or have you previously experienced, sinus problems?

- ☐ Yes, currently
- ☐ Yes, previously
- ☐ Yes, both currently and previously
- ☐ No
- ☐ Unsure

If yes, which symptoms do you experience? (Check all that apply.)

- ☐ Chronic sinus congestion
- ☐ Sinus pressure or pain
- ☐ Frequent sinus infections
- ☐ Nasal drainage or postnasal drip
- ☐ Nasal dryness or irritation
- ☐ Reduced sense of smell
- ☐ Other: _____

17. Have your sinus problems been formally diagnosed by a healthcare professional?

- ☐ Yes
- ☐ No
- ☐ Currently undergoing evaluation
- ☐ Not applicable

If yes, what was the diagnosis (for example, chronic sinusitis, allergies, or nasal polyps)?

Approximately when were you diagnosed?

18. Do you experience itching around your nose, inside your nose, around your eyes, or along your eyelids?

- ☐ Yes, frequently
- ☐ Yes, occasionally
- ☐ No
- ☐ Unsure

If yes, where does the itching occur? (Check all that apply.)

- ☐ Inside the nose
- ☐ Outside or around the nose
- ☐ Around the eyes
- ☐ Eyelids or eyelashes
- ☐ Eyebrows
- ☐ Other: _____

Please describe when the itching occurs and whether anything seems to trigger it.

19. Do your Parkinson's disease or other neurological symptoms worsen when you experience sinus problems?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Unsure
- ☐ Not applicable (control participant)

If yes, which symptoms worsen? (Check all that apply.)

- ☐ Tremors
- ☐ Muscle stiffness or rigidity
- ☐ Slowed movement
- ☐ Balance or walking difficulties
- ☐ Dystonia or muscle spasms
- ☐ Cognitive difficulties or brain fog
- ☐ Fatigue
- ☐ Sleep disturbances
- ☐ Other: _____

Please describe any relationship you have noticed between sinus flare-ups and neurological symptoms.

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20. Have you received treatment for sinus, skin, or eye conditions and noticed any changes in your Parkinson's disease or other neurological symptoms?

- ☐ Yes, neurological symptoms improved
- ☐ Yes, neurological symptoms worsened
- ☐ No noticeable change
- ☐ Unsure
- ☐ Have not received treatment
- ☐ Not applicable (control participant)

If applicable, what condition was treated?

- ☐ Sinus condition
- ☐ Skin condition
- ☐ Eye condition
- ☐ Other: _____

What treatment did you receive? (For example, antibiotics, antiparasitic treatments, eye drops, nasal sprays, topical creams, or other medications.)

Approximately when did treatment begin?

Which neurological symptoms changed, and how soon after treatment did you notice the changes?

Did the changes last?

- ☐ Yes
- ☐ No
- ☐ Symptoms returned after treatment
- ☐ Unsure

Additional comments:

Section 6: Environmental Exposure and Vector Testing

Certain environmental organisms, mites, parasites, and vector-associated exposures have been investigated for possible relationships with inflammation or neurological health. Further investigation is needed to understand whether any of these factors contribute to neurodegenerative diseases.

21. Would you be interested in environmental testing for vectors?

- ☐ Yes
- ☐ No

22. Have you previously experienced or been diagnosed with any of the following?

- ☐ Demodex mite overgrowth
- ☐ Scabies
- ☐ Significant dust mite allergies
- ☐ Tick bites or tick-borne illness
- ☐ Other suspected mite or parasite exposure
- ☐ None known
- ☐ Unsure

If applicable, please describe:

23. If your neurological, gastrointestinal, sinus, skin, or eye symptoms noticeably improve or worsen, would you be interested in repeat testing to help us identify potential changes?

- ☐ Yes
- ☐ No
- ☐ Maybe — depending on the testing involved

Section 7: Additional Information

24. Are there any environmental changes, medical treatments, dietary adjustments, or lifestyle changes that you believe have significantly affected your health?

25. Is there anything else about your symptoms, medical history, or personal experiences that you believe should be investigated?

26. Would you be interested in receiving information about future INSIGHT research opportunities?

- ☐ Yes
- ☐ No
- ☐ Maybe

Additional Comments

Section 8: Consent and Privacy Statement

Purpose and Voluntary Participation

The INSIGHT Institute for Neurodegenerative Research is collecting information to better understand individuals' experiences with neurological diseases and other health

conditions. Responses may help identify patterns and guide decisions about future investigations.

Participation is entirely voluntary. You may skip questions or choose not to participate without penalty or any effect on your medical care.

Privacy and Confidentiality

INSIGHT intends to protect participant privacy through the following procedures:

- Questionnaire responses will be identified by a participant number in our computer system rather than a name.
- Access to identifiable health information will be limited to authorized INSIGHT personnel involved in reviewing the responses.
- Personal contact information, if collected, will be maintained separately from questionnaire responses whenever practical.
- General findings and patterns will be summarized without identifying individual participants.

Although reasonable measures will be taken to protect information, absolute confidentiality cannot be guaranteed.

Use of Information and Future Testing

The information collected will be used to help INSIGHT determine which symptoms, environmental factors, and potential associations deserve further investigation.

Completing this questionnaire does not authorize collection of biological or environmental samples, additional medical testing, or access to medical records. Any future testing or participation will require a separate explanation and consent process.

Questionnaire responses are not intended to diagnose disease or establish that an exposure caused a particular health condition.

Withdrawal of Consent

Participants may contact INSIGHT at info@insightnd.org to request withdrawal of their questionnaire information. Identifiable information will be withdrawn from future use when reasonably possible. Information already combined into summaries that cannot be linked back to an individual may not be removable.

Participant Consent

Please indicate your choice:

☐ **I agree** to voluntarily provide my questionnaire responses to the INSIGHT Institute for Neurodegenerative Research for exploratory review and to help guide future investigations. I understand how my information is intended to be used and protected.

☐ **I do not agree** to have my questionnaire responses used for these purposes.

Consent provided by:

☐ Participant

☐ Legally authorized representative acting on behalf of the participant

Participant : _____

Email : _____

Date: _____

Thank You for Participating

Your experiences and observations may help INSIGHT recognize patterns, identify unanswered questions, and guide future investigations into neurological health, gastrointestinal conditions, skin and eye symptoms, sinus issues, and environmental exposures.

INSIGHT Institute for Neurodegenerative Research

Website: www.insightnd.org

Email: info@insightnd.org

This questionnaire is intended for exploratory information gathering and is not a diagnostic tool. Reported associations do not establish cause and effect.