Subjective Peripheral Neuropathy Screen Questionnaire

Full name: ____________________________________________ Date ____________

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Check yes or no based on how you usually feel. Thank you.

1. Do you ever have legs and/or feet that feel numb?  Yes  No
2. Do you ever have any burning pain in your legs and/or feet?  Yes  No
3. Are your feet too sensitive to touch?  Yes  No
4. Do you get muscle cramps in your legs and/or feet?  Yes  No
5. Do you ever have any prickling or tingling feelings in your legs or feet?  Yes  No
6. Does it hurt at night or when the covers touch your skin?  Yes  No
7. When you get into the tub or shower, are you unable able to tell the hot water from the cold water?  Yes  No
8. Do you ever have any sharp, stabbing, shooting pain in your feet or legs?  Yes  No
9. Have you experienced an asleep feeling or loss of sensation in your legs or feet?  Yes  No
10. Do you feel weak when you walk?  Yes  No
11. Are your symptoms worse at night?  Yes  No
12. Do your legs and/or feet hurt when you walk?  Yes  No

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13. Are you unable to sense your feet when you walk? Yes
   No

14. Is the skin on your feet so dry that it cracks open? Yes
   No

15. Have you ever had electric shock-like pain in your feet or legs? Yes No

Full name: _______________________________ Date ____________

This questionnaire asks you about the intensity of symptoms in legs and feet you may experience. Please provide answers based upon your experience of the symptoms in legs and feet over the period of the past week only. Thank you for helping.

1. How would you rate the discomfort in your legs?
   (4) Very severe
   (3) Severe
   (2) Moderate
   (1) Mild
   (0) None in the past week

2. How would you rate the need to move around your leg symptoms?
   (4) Very severe
   (3) Severe
   (2) Moderate
   (1) Mild
   (0) None in the past week

3. How much relief of your leg discomfort did you get from moving around?
   (4) No relief
   (3) Mild relief
   (2) Moderate relief
   (1) Either complete or almost complete relief
   (0) No RLS symptoms to be relieved

4. How severe was your sleep disturbance due to your leg symptoms?
   (4) Very severe
   (3) Severe
   (2) Moderate
   (1) Mild
   (0) None in the past week

5. How severe was your tiredness or sleepiness during the day due to your leg symptoms?
   (4) Very severe
   (3) Severe
   (2) Moderate
   (1) Mild
   (0) None in the past week

6. How severe was your leg symptoms as a whole?
   (4) Very severe
   (3) Severe
   (2) Moderate
   (1) Mild
   (0) None in the past week

7. How often did you get leg symptoms?
   (4) Very often (6 to 7 days in 1 week)
   (3) Often (4 to 5 days in 1 week)
   (2) Sometimes (2 to 3 days in 1 week)
   (1) Occasionally (1 day in 1 week)

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8. When you had leg symptoms, how severe were they on average?
   (4) Very severe (8 hours or more per 24 hour)
   (3) Severe (3 to 8 hours per 24 hour)
   (2) Moderate (1 to 3 hours per 24 hour)
   (1) Mild (less than 1 hour per 24 hour)
   (0) None In the past week...

9. Overall, how severe was the impact of your leg symptoms on your ability to carry out your daily affairs, for example carrying out a satisfactory family, home, social, school or work life?
   (4) Very severe
   (3) Severe
   (2) Moderate
   (1) Mild
   (0) None in the past week

10. How severe was your mood disturbance due to your leg symptoms – for example angry, depressed, sad, anxious or irritable?
    (4) Very severe
    (3) Severe
    (2) Moderate
    (1) Mild
    (0) None in the past week

    Thank you for completing this questionnaire.