Neuropathy Specific Questionnaire

What do you think is the cause of your neuropathy?

_____

Please rate the severity:

- ☐ MINIMAL (Annoying but causing NO limitations)
- ☐ SLIGHT (Tolerable but causing a little limitation)
- ☐ MODERATE (Sometimes tolerable but definite
- ☐ SEVERE (Causing Significant limitations)
- ☐ EXTREME (Causing near constant limitations)
- ☐ THE PROBLEM IS GETTING WORSE

HOW WOULD YOU DESCRIBE YOUR SYPMTOMS (Circle any that apply)	Stabbing-Sharp	Electric Shocks	Cold	Tingling	Pins + Needles	Dead Feeling	Throbbing
	Burning	Stings	Ache	Numbness	Swelling	Tiredness	Cramping

Do you have a Pacemaker/Defibrillator? ☐Yes ☐ No

Have you ever had a thrombosis (blood clot)? ☐Yes ☐ No If yes, when & where? _____

Have you ever had a surgical repair of an abdominal aortic aneurysm? ☐ Yes ☐ No

When did you last have blood tests?_____ Are you aware of any abnormal findings? ☐ Yes ☐ No

If yes, what was abnormal?_____

Has your **balance** or ability to walk been affected yet? ☐Yes ☐ No If yes, describe below in what way(s):

_____

Please complete this section thoroughly. **Mark** a "√" if you've experienced any of the following:

- ☐ Diabetes: Type I, II (Last A1c: _____)
- ☐ Chemotherapy
- ☐ Cancer (_____)
- ☐ High Cholesterol
- ☐ Taking Statins
- ☐ Lower Back Pain
- ☐ Chronic Neck or Back Pain
- ☐ Spine Surgery – describe: (_____)
- ☐ Heavy Metal Toxicity
- ☐ Alcohol Abuse
- ☐ Drug or Substance Abuse
- ☐ Shingles
- ☐ HIV/AIDS
- ☐ Stroke (date:_____)
- ☐ Seizures
- ☐ Dizziness / Balance
- ☐ Walking Difficulty
- ☐ Numbness in Hands
- ☐ Numbness in Feet
- ☐ Swollen Ankles/Feet
- ☐ Feet, Ankle or Hands Discolored
- ☐ Feet, Ankle or Hands Cold
- ☐ Fatigue
- ☐ Poor Circulation
- ☐ Plantar Fasciitis
- ☐ Spinal Stenosis
- ☐ Kidney Dialysis
- ☐ Chemical Exposure

Continued on Reverse Side

WALKING LIMITATIONS

These questions ask about limitations to your ability to walking due to altered sensation in your feet, fatigue, instability, disequilibrium or dizziness during the **past 4 weeks**. For each statement please circle the one number that best describes your degree of limitation. Please check that you have circled one number for each question.

In the past 4 weeks how much have your symptoms effected the following:	Not at all	A little 25%	Moderately 50%	Quite a bit 75%	Extremely 100%
Limited your ability to walk?	**1**	**2**	**3**	**4**	**5**
Limited your ability to run?	**1**	**2**	**3**	**4**	**5**
Limited your ability to climb up or down stairs?	**1**	**2**	**3**	**4**	**5**
Made standing when doing things more difficult?	**1**	**2**	**3**	**4**	**5**
Impaired your balance when standing or walking?	**1**	**2**	**3**	**4**	**5**
Limited how far you can walk without stopping?	**1**	**2**	**3**	**4**	**5**
Increased the effort needed for you to walk?	**1**	**2**	**3**	**4**	**5**
Made it necessary for you to use supports when walking **indoors** e.g. holding on to furniture, using a cane, etc?	**1**	**2**	**3**	**4**	**5**
Made it necessary for you to use support when walking **outdoors**, e.g. using a cane or walker, etc?	**1**	**2**	**3**	**4**	**5**
Slowed down your pace walking?	**1**	**2**	**3**	**4**	**5**
Affected how smoothly you walk?	**1**	**2**	**3**	**4**	**5**
Made you concentrate on your walking?	**1**	**2**	**3**	**4**	**5**

WALKING SCALE QUESTIONAIRE SCORE TOTAL _____

DISABILITY SCORE: 12 NORMAL, 13-27 MILD, 28-45 MODERATE, >46 SEVERE DISABILITY