Peripheral Neuropathy Screening Questionnaire

Full name:(Print) ______________________________ Date __________

Address:_________________________ Town:______ / State:___ / Zip:______

Please take a few minutes to "print out" and answer the following questions about the feeling in your legs and feet. Check [x] Yes **or** [x] 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 to tell the hot water from the cold water with your feet**? [ ] 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
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
16. Are your peripheral neuropathy related symptoms **ruining the quality of your life**? [ ] Yes // [ ] No

Once you have completed the questionnaire, you can either email the results to:
"Dr. Michael Taylor" <drtaylor@healinginc.net> or fax them to: 918-749-1536.
To call and discuss the findings, please call 918-749-3797.