Summit Chiropractic Small Fiber Peripheral Neuropathy Questionnaire on Quality of Symptoms.
Please fill out some with a yes or no and or elaborate on your condition.

1. Have you experienced electric shock like sensations in your feet or legs?  Yes__ No__
2. Experience sharp, stabbing shooting pain in legs or feet?  Yes__ No__
3. When are your symptoms worse during a 24 hour day?  ____________
4. Experience tingling or prickly feelings in feet and legs?  Yes__ No__
5. Experience burning on your feet when you touch them?  Yes__ No__
6. Is any part of your lower extremity too sensitive to touch?  Yes__ No__
7. Experience a feeling of any part of your lower extremity falling asleep or loss of sensation?  Yes__ No__
8. Experience any feeling of being bloated (full swollen) in your lower extremities?  Yes__ No__
9. Experience pain with a light touch of your lower extremities?  Yes__ No__
10. Experience pain in feet or legs while walking?  Yes__ No__
11. Experience inability to walk without looking at your foot position in relation to the ground?  Yes__ No__
12. Experience feet so dry they develop cracks and sometimes bleed?  Yes__ No__
13. Experience a sensation of malaise or weakness when walking as if your lower extremities will give way and you may fall?  Yes__ No__
14. Experience the sensation of burning when cold water falls on your lower extremities or cannot gauge the temperature differential between warm and scalding water?  Yes__ No__
15. Experience any pain in your feet at night that wakes you up?  Yes__ No__
16. Is there any muscle cramping noted during your 24 hour day?  Yes__ No__
17. Experience numbness in your legs or feet?  What color are your lower extremities?  Yes__ No__
18. What activities of daily living are limited by your condition?  __________________________
19. On a scale of 1-10 (10 being disabled) how limited are you in performing normal daily activities?  __________________________

Name: __________________________________________ Date: ____________
Name: _______________________________________________ Date: __________

Chief Complaint: ________________________________________________

History:

When did you first notice symptoms? _______________________________
How did it happen? _____________________________________________
How often do you experience symptoms? 0% - 100%? How long does it last? __________

Again, please describe the intensity of pain from 1-10 __________________________
Happened Before? When? __________________________________________

Palliative/Provocative:

What exacerbates or ammenorates the symptoms? ___________________________
What body position improves symptoms or aggravates them? _________________
How do activities affect your condition or therapies or medications? _________________

Quality/Quantity:

Please describe the quality or Quantity of your condition? Ex sharp, electrical, dull, achy, stiff. Again, how does this affect your activities of daily living at its worst or best? _________________

Referral of Pain:

Is there referral or radiating of pain from one point in your body to another? Yes__ No__
How long does the pain last?

____________________________________________________________________________

Site:

Does your pain site change with different locations such as at home or work, etc? Yes__ No__

Time:

Is there a change in your presenting symptoms from different times of day? _________________
During that time is the pain constant or episodic? _________________