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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? _____

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