

Health & Peripheral Neuropathy Evaluation

Name: _____ Date: _____

Address: _____ Age: _____ Sex: _____

City: _____ CA Zip: _____ Phone: _____

email: _____

1) Check off any of the following symptoms you have experienced in the last 6 months:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pain between the shoulders |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Tired / Fatigued | <input type="checkbox"/> Allergies / Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hip / Leg / Knee Pain | <input type="checkbox"/> Numbness / Tingling in Arms or Legs |
| <input type="checkbox"/> Wrist / Hand Pain | <input type="checkbox"/> Stress | <input type="checkbox"/> Dizziness / Nervous / Tension |

Which of the above is the worst? _____ How long have you had it? _____

2) Please answer a few questions about pain in your legs or feet:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Do you ever have legs and/or feet that feel numb? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you ever have burning pain in your legs and/or feet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are your feet too sensitive to touch? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you get muscle cramps in your legs and/or feet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Do you ever have prickling or tingling feelings in your legs or feet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Does it hurt at night or when the covers touch your skin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. When you get into the tub or shower, are you unable able to tell the hot water from the cold water? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Do you ever have sharp, stabbing, shooting pain in your feet or legs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Have you experienced an asleep feeling or loss of sensation in your legs or feet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Do you feel weak when you walk? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Are your symptoms worse at night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Do your legs and/or feet hurt when you walk? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Are you unable to sense your feet when you walk? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Is the skin on your feet so dry that it cracks open? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Have you ever had electric shock-like pain in your feet or legs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered Yes to 2 or more of these questions, you may have nerve damage called Neuropathy and should be evaluated in our office.

Tester to fill out below this line

Brief Scanning Analysis	Risk Factors																		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Right Leg</td> <td style="width: 50%;">Left Leg</td> </tr> <tr> <td>0 1 2 3 4 5 6 7 8 9 10 -5 Cool</td> <td>0 1 2 3 4 5 6 7 8 9 10 -5</td> </tr> <tr> <td>0 1 2 3 4 5 6 7 8 9 10 -5 Vibrate</td> <td>0 1 2 3 4 5 6 7 8 9 10 -5</td> </tr> <tr> <td>0 1 2 3 4 5 6 7 8 9 10 -5 Wheel</td> <td>0 1 2 3 4 5 6 7 8 9 10 -5</td> </tr> <tr> <td>0 1 2 3 4 5 6 7 8 9 10 -5 Pin</td> <td>0 1 2 3 4 5 6 7 8 9 10 -5</td> </tr> <tr> <td>0 1 2 3 4 5 6 7 8 9 10 -5 Light</td> <td>0 1 2 3 4 5 6 7 8 9 10 -5</td> </tr> <tr> <td style="padding-left: 40px;">0 1 2 Patellar</td> <td>0 1 2</td> </tr> <tr> <td style="padding-left: 40px;">0 1 2 Achilles</td> <td>0 1 2</td> </tr> <tr> <td>Rt _____ / 54 Total Score</td> <td>Lt _____ / 54</td> </tr> </table>	Right Leg	Left Leg	0 1 2 3 4 5 6 7 8 9 10 -5 Cool	0 1 2 3 4 5 6 7 8 9 10 -5	0 1 2 3 4 5 6 7 8 9 10 -5 Vibrate	0 1 2 3 4 5 6 7 8 9 10 -5	0 1 2 3 4 5 6 7 8 9 10 -5 Wheel	0 1 2 3 4 5 6 7 8 9 10 -5	0 1 2 3 4 5 6 7 8 9 10 -5 Pin	0 1 2 3 4 5 6 7 8 9 10 -5	0 1 2 3 4 5 6 7 8 9 10 -5 Light	0 1 2 3 4 5 6 7 8 9 10 -5	0 1 2 Patellar	0 1 2	0 1 2 Achilles	0 1 2	Rt _____ / 54 Total Score	Lt _____ / 54	<input type="checkbox"/> Age: _____ <input type="checkbox"/> Ht: _____' _____" Weight: _____ lbs <input type="checkbox"/> Blood Pressure: _____ / _____ Pulse: _____ <input type="checkbox"/> Diabetic: How Long _____ Yrs Controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Meds <input type="checkbox"/> Insulin Injection <input type="checkbox"/> Medication: _____ <input type="checkbox"/> Statin Drugs: Lipitor, Mytorin, _____ <hr/> <p style="text-align: center;">Appointment:</p> Date _____ Day: _____ Time: _____
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0 1 2 3 4 5 6 7 8 9 10 -5 Cool	0 1 2 3 4 5 6 7 8 9 10 -5																		
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