Final Questionnaire for Neuropathic Pain

Patient: _____Gender:_____Age: _____ Date: _____

You must answer each question. We are only asking about your NERVE SYMPTOMS that are still present. Please take your time and give the best response possible.

1. **DESCRIBE** the Nerve Symptoms you still have in your feet after treatment, check all that apply.
   □ **Sharp Pain** □ **Dull Ache** □ **Shooting** □ **Throbbing** □ **Stabbing** □ **Numbness** □ **Burning**
   □ **Foot/Leg Cramps** □ **Pins and Needles** □ **Freezing Pain** □ **Electric Shock** □ **Tight Band**

2. Your Nerve Symptoms start in your toes and go **HOW FAR UP**?
   □ **Toes Only** □ **Middle of Foot** □**Ankle** □ **Shin** □ **Knee**

3. Describe the **FREQUENCY** of your current Nerve Symptoms in your feet.
   □ **Constant (100%)** □ **Sometimes (25-50%)** □ **Frequent (50-75%)** □ **Occasionally (25% or Less)**

4. How much has treatment improved your quality of **SLEEP**? _____ %

5. Have you **FALLEN LESS** while going through treatment? □ Yes □ No

6. Do you have **LESS FEAR of FALLING** now? □ Yes □ No

7. How much has treatment improved your **BALANCE** and/or **COORDINATION**? _____ %

8. How much has treatment improved the **SWELLING** in your feet and legs? _____ %

9. How much has treatment improved your ability to **FEEL** things with your feet? _____ %

10. Can you tell the **DIFFERENCE** between hot and cold water with your feet? □ Yes □ No

11. Do things that should **NOT** hurt your feet cause your feet pain (ex: Someone lightly touching your feet hurts you? The bed sheets touching your feet hurt?) □ Yes □ No

12. How has the amount of **MEDICINE** you take for your Nerve Pain changed?
    □ Same Amount □ Increased □ Decreased □ Stopped Completely □ Never took meds

13. If you decreased the amount of **MEDICINE**, how much do you take now each day? _____ mg

14. Do you plan on asking your family doctor about **DECREASING** or **STOPPING** your Nerve Pain medication? □ Yes □ No □ Not applicable to me

15. How much has treatment improved your **RESTLESS LEG SYNDROME**? _____ %

16. Did you have **LOWER BACK PAIN** before treatment began? □ Yes □ No

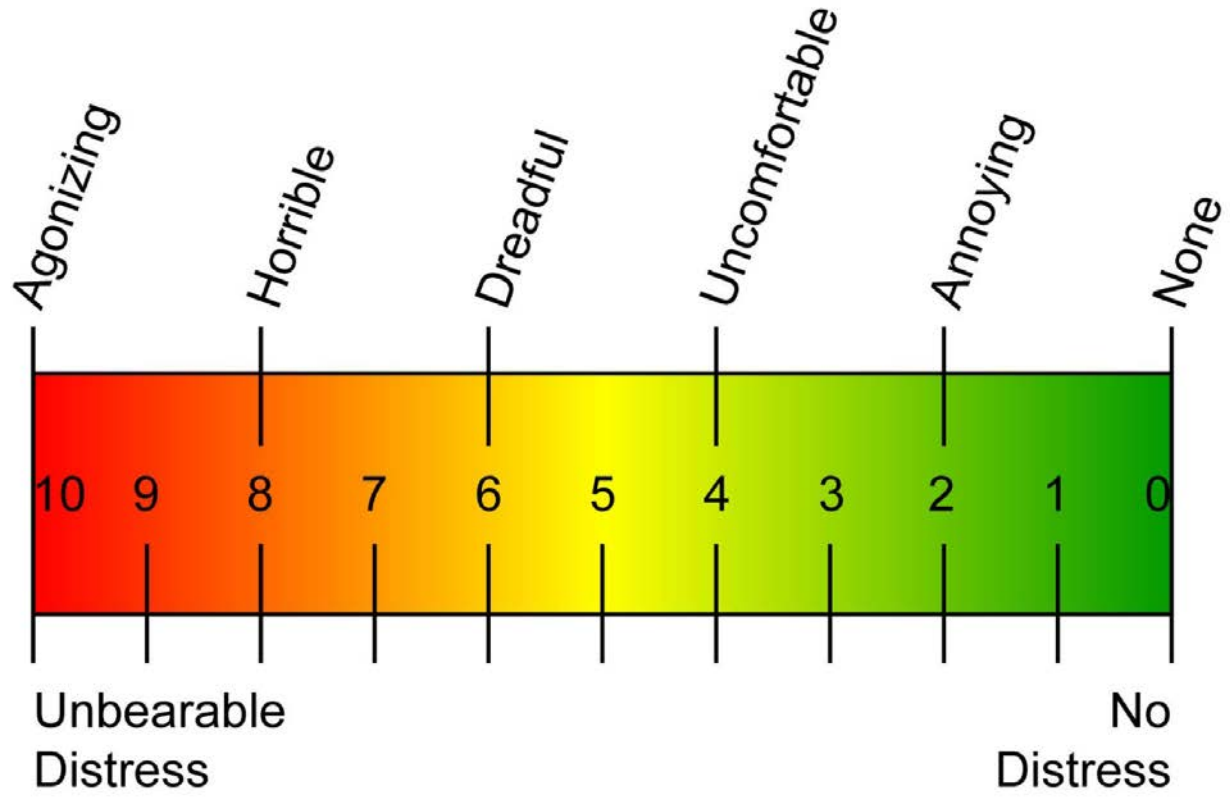
17. If yes, how much has treatment improved your **LOWER BACK PAIN**? _____ %

18. Can you be on your feet **LONGER** each day because of treatment? □ Yes □ No
19. If yes, how much **LONGER** each day? □ 30 minutes □ 1 hour □ 2 hours □ 3 hours or more
20. During treatment did your Nerve Symptoms get **WORSE** for a short period of time? □ Yes □ No
21. Towards the end of the treatment could you feel the effects of the shots **GREATER**? □ Yes □ No

22. How much has treatment improved the **NERVE PAIN** in your feet? _____ %
23. How successful **OVERALL** was treatment for improving all of your Nerve Symptoms? _____ %
24. Please check one of the following choices describing your treatment **SATISFACTION LEVEL**?
    - □ **Completely Satisfied** □ **Somewhat Satisfied** □ **Somewhat Dissatisfied**
    - □ **Completely Dissatisfied** □ **Indifferent (neither Satisfied nor Dissatisfied)**
25. Would you **RECOMMEND** this treatment to another patient? □ Yes □ No
26. Do you feel the **NUMBER** of treatments you had were: □ too few □ too many □ just about right
27. List any **CHANGES** you have noticed in your back, hips, legs, and feet that are not listed above.

Below is a Pain Scale. Think carefully about how much **NERVE** pain you have in your feet. We realize everyday is different and certain parts of the day may be more painful than other.

Circle **TWO** numbers below that best represents how much **NERVE** pain you have in your feet on a typical, average day. One for **WORST** and one for **BEST**.



How many hours of your day are your NERVE symptoms at their WORST? _____

How many hours of your day are your NERVE symptoms at their BEST? _____