1st Treatment Questionnaire for Neuropathic Pain

Patient: _____Gender:_____Age: _____ Date: _____

You must answer each question. We are only asking about your NERVE SYMPTOMS, not any other foot symptoms. Please take your time and give the best response possible.

1. **DESCRIBE** the Nerve Symptoms in your feet, 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. How **LONG** have you had the Nerve Symptoms in your feet? _____ Years _____ Months
3. Your Nerve Symptoms start in your toes and go **HOW FAR UP**?
   □ Toes only □ Middle of Foot □Ankle □ Shin □ Knee
4. What part of the foot are your Nerve Symptoms the **WORST**?
   □ Top of the Foot □ Bottom of the Foot □ Both the bottom and the top are equal
5. Do you have Nerve Symptoms in **BOTH** feet? □ Yes □ No
   If no, which one only? _____ If yes, which one is worse? □ Right □ Left □ About the same
6. Describe the **FREQUENCY** of the Nerve Symptoms in your feet.
   □ Constant (100%) □ Frequent (50-75%) □ Sometimes (25-50%) □ Occasionally (25% or Less)
7. Are the Nerve Symptoms in your feet worse at **NIGHT**? □ Yes □ No
8. Do the Nerve Symptoms in your feet cause you to lose **SLEEP** at night? □ Yes □ No
9. Do you lose your **BALANCE** or **FALL** more often than you should? □ Yes □ No
10. Do you have **SWELLING** in your feet and/or lower legs? □ Yes □ No
11. Do you believe you have lost some **FEELING** in your feet? □ Yes □ No
12. Can you tell the **DIFFERENCE** between hot and cold water with your feet? □ Yes □ No
13. Do things that should **NOT** hurt your feet cause foot pain (ex: Someone lightly touching you foot hurts you? The bed sheets touching your feet hurts?) □ Yes □ No
14. Have you seen a **NEUROLOGIST** and had tests for your Nerve Symptoms? □ Yes □ No
15. Mark the medicine(s) and dosage you currently take **DAILY** for your Nerve Symptoms.
    □ Elavil (Amitriptyline) _____ mg □ Neurontin (Gabapentin) _____ mg □ Cymbalta _____ mg
    □ Lyrica (Pregabalin) _____ mg □ Metanx (Vitamin) _____ mg □ _____ _____ mg
16. Have you been diagnosed with **RESTLESS LEG SYNDROME**? □ Yes □ No
17. Are you a **DIABETIC**? □ Yes □ No If yes, what year were you diagnosed? _____

18. Have you ever had **CANCER**? □ Yes □ No If yes, year you received treatment? _____

19. What kind of **TREATMENT** did you receive for your Cancer?

□ Chemotherapy □ Radiation □ Oral Medications □ Topical Medications □ Surgical Removal

20. Do you have **LOWER BACK PAIN**? □ Yes □ No If yes, is it □ Severe □ Moderate □ Mild

21. Do you sometimes have pain that shoots into the **BACK OF YOUR THIGHS**? □ Yes □ No

22. Have you ever had **LOWER BACK SURGERY**? □ Yes □ No If Yes, what year? _____

23. Mark any **LOWER BACK** issues you have today or have had in the past.

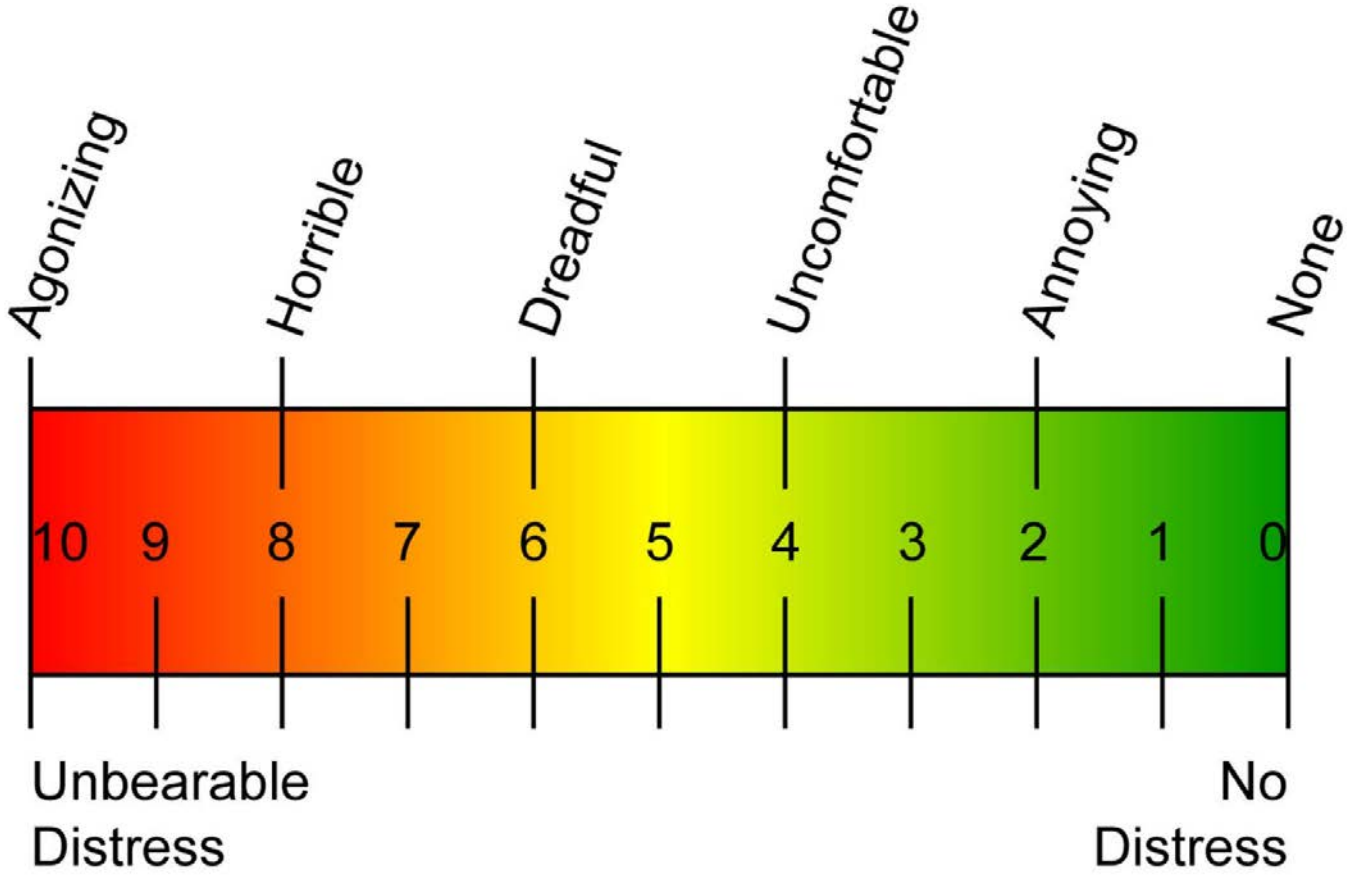
□ Lower Back Arthritis □ Spinal Stenosis □ Herniated/Bulging Disc □ Degenerative Disc □ Trauma

□ Sciatica □ Implanted Back Stimulator □ Spine Infection □ Spinal Tumor □ Spine Bone Spurs

24. What do **YOU** believe caused the Nerve Symptoms in your feet?_____

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 others.

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? _____