NEUROPATHY QUESTIONNAIRE

This questionnaire must be completed prior to your first appointment with our office. Your careful answers will help us to understand your pain problem and to better assess your treatment plan.

***DATE OF APPOINTMENT**:* _______________________

NAME: ____ ***DOB:*** _______________________

1) **How is your overall health today?** ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

2) **What is the reason for your visit today?**
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3) **How long have you been experiencing the symptom(s)?** ____

4) **Have you been diagnosed with Neuropathy?** ( ) Yes ( ) No
   If yes; how long have you been diagnosed with Neuropathy? ______________________________

5) **Have you been diagnosed with Diabetes?** ( ) Yes ( ) No
   If yes; how long have you been diabetic? ____
   If you have been diagnosed with Diabetes, how is this being treated? ______________________
   ____

6) **Have you ever been diagnosed with and/or experienced any of the following:**

( ) Chronic Pain Syndrome ( ) Lower Back Stenosis ( ) Herniated Disc ( ) Sciatica ( ) Radiculopathy

7) **Have you undergone Chemotherapy?** ( ) Yes ( ) No
   Did Neuropathy occur as a result of Chemotherapy? ( ) Yes ( ) No

8) **Do you have a history of or been diagnosed with alcohol abuse?** ( ) Yes ( ) No

9) **Do you have a history of or been diagnosed and/or treated for high cholesterol/triglycerides?** ( ) Yes ( ) No

10) **Have you ever been exposed to hazardous materials/chemicals?** ( ) Yes ( ) No
   If yes, were you exposed to any of the following?
   ( ) Agent Orange ( ) Heavy Metals ( ) Dangerous Solvents ( ) Other: __________________

11) **How would you describe the quality of your Neuropathy symptoms?**

( ) Not Painful ( ) Painful ( ) Numbness

If painful, how often do you feel pain?

( ) 100% of the time ( ) 76-99% of the time ( ) 51-75% of the time

( ) 26-50 of the time ( ) Less than 25% of the time ( ) No Pain

If experiencing numbness, how often does it occur?

( ) 100% of the time ( ) 76-99% of the time ( ) 51-75% of the time

( ) 26-50 of the time ( ) Less than 25% of the time ( ) No numbness

12) **Do any of the following symptoms occur with your Neuropathy?**

Numbness	Tingling	Lack of Balance	Difficulty Sensing Feet when Walking	Difficulty Sensing Ground Surface
Weakness of Leg Muscles	Burning Pain	Sharp Pain	Throbbing Pain	Electric Pain
Aching Pain	Shooting Pain	Stinging Pain	Cramping Pain	Squeezing Pain (feels like foot is in vice)
Hypersensitivity to Light Touch	Urinary Incontinence	Bowel Incontinence	Worse at Night	Worse w/ Shoes on

13) **How would you grade the severity of your symptoms?** ( ) Mild ( ) Moderate ( ) Severe

14) **Do the symptoms or pain interrupt your sleep?** ( ) Yes ( ) No

15) **How would you describe the onset of your symptoms?** ( ) Sudden ( ) Gradual

16) **Are your symptoms constant or intermittent (comes and goes)?** ( ) Constant ( ) Intermittent

If your symptoms are intermittent, when do you experience them more? ____________________

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17) **What makes the neuropathy symptoms worse?**

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18) **What makes the neuropathy symptoms better?**

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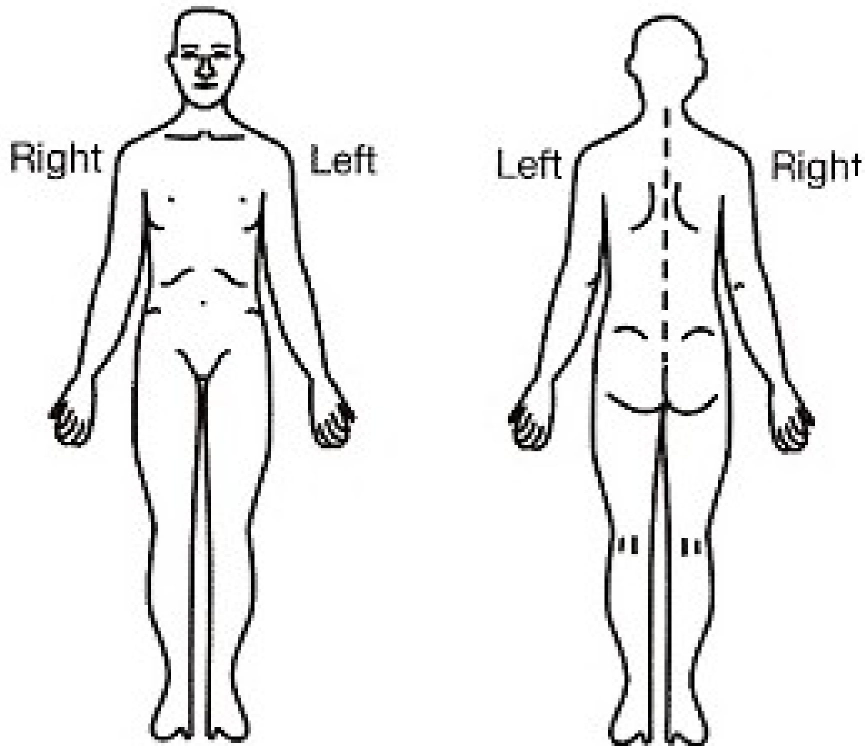
19) **DESCRIBE THE LOCATION(S) OF YOUR SYMPTOMS**:
On the diagram below, shade in all the areas where you feel pain. If there is more than one location, then please write #1 for the worst, #2 for second worst, #3 for next worst, etc.



Right Foot

Left Foot

20) **Self Treatment:** Have you tried any over-the-counter medications/devices to treat your symptoms? (

) Yes ( ) No

If yes, what is the name or type of medication/device? ____________________________________

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21) **PAST & CURRENT TREATMENTS FOR THESE SYMPTOMS:** Please check all treatments you have tried and the following questions:

X	Treatment Name	Years Taken	Still Taking?	Did This Help?	Reason For Stopping
	Neurontin/gabapentin		Yes / No	Y / N / Somewhat	
	Cymbalta		Yes / No	Y / N / Somewhat	
	Lyrica		Yes / No	Y / N / Somewhat	
	Pain Medication		Yes / No	Y / N / Somewhat	
	Acupuncture		Yes / No	Y / N / Somewhat	
	Physical Therapy		Yes / No	Y / N / Somewhat	
	Spinal Injections		Yes / No	Y / N / Somewhat	
	Cold Laser		Yes / No	Y / N / Somewhat	
	CET		Yes / No	Y / N / Somewhat	
	Surgery		Yes / No	Y / N / Somewhat	

22) **Have you had any tests performed related to your Neuropathy symptoms?** ( ) Yes ( ) No

If yes, which of the following tests have you had?

( ) Nerve Conduction Velocity Test ( ) Electromyelogram ( ) Nerve Biopsy

( ) Epidermal Nerve Fiber Density Test [ENFD] ( ) PSSD

23) **Have you had any recent radiological exam(s) related to your Neuropathy symptoms?** ( ) Yes ( ) No

If yes, which of the following tests have you had?

( ) Regular X-ray ( ) CAT Scan ( ) MRI ( ) Ultrasound ( ) Bone-scan ( ) Vascular Test

24) **Has anyone in your family had Neuropathy?** ( ) Yes ( ) No

If yes, whom? ( ) Mother ( ) Father ( ) Sibling ( ) Grandparent ( ) Other: ______________

25) **Do you currently use a defibrillator/pacemaker?** ( ) Yes ( ) No

26) **Do you feel that your Neuropathy symptoms are affecting you emotionally?** ( ) Yes ( ) No

If yes, please describe: ______________________________

27) **Treatment Goals:** Describe what you hope to get out of CET Neuropathy treatment in terms of less pain, better quality of life, etc…

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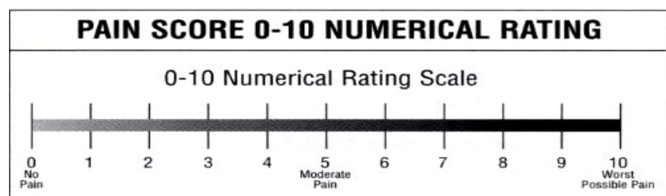
SEVERITY OF PAIN/VISUAL ANALOG SCALE

Please rate all of these on a scale of 0-10, with 0 being none and 10 being the worst possible case



1) Your PAIN at its WORST this past month was: (no pain) 0 1 2 3 4 5 6 7 8 9 10
2) Your PAIN at its LEAST this past month was: (no pain) 0 1 2 3 4 5 6 7 8 9 10
3) Your PAIN RIGHT NOW is: (no pain) 0 1 2 3 4 5 6 7 8 9 10

The SYMPTOM(S) you have is INTERFERING with:

4) Your ability to walk: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
5) Ability to walk without use of a cane, walker, or other assistive device: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
6) Ability to sit: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
7) Ability to stand: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
8) Ability to climb stairs: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
9) Perform daily activities, such as carrying groceries or holding a book: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
10) Ability to bathe self: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
11) Strength and endurance: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
12) Physical activity: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
13) Ability to exercise or be active for fear of injuring self: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
14) Overall energy: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
15) Self-esteem or self-worth: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
16) Overall concentration: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
17) Overall mood: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
18) Normal work: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
19) Sleep: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
20) Family relationship: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
21) Social activities with others: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)
22) Enjoyment of life: (no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely interferes)