Name: _____ DOB: _____ Date: _____

BELLEVUE PAIN INSTITUTE
relief repair renew

Answer the following questions about the feeling in your hands, legs and/or feet.

Check **YES** or **NO** based on what you have felt.

1. Do you ever have hands, legs and/or feet that feel numb?	☐ Yes ☐ No
2. Do you ever have any burning pain in your hands, legs or feet?	☐ Yes ☐ No
3. Are your hands or feet too sensitive to touch?	☐ Yes ☐ No
4. Do you get muscle cramps in your legs and/or feet?	☐ Yes ☐ No
5. Do you ever have any prickling or tingling feelings in your hands, legs or feet?	☐ Yes ☐ No
6. Does it hurt at night or when the covers touch your skin?	☐ Yes ☐ No
7. When you get into the tub or shower, are you unable to sense the hot water from the cold water with your feet?	☐ Yes ☐ No
8. Do you ever have any sharp, stabbing, shooting pain or electric shock-like pain in your legs or feet?	☐ Yes ☐ No
9. Are your symptoms worse at night or affecting your sleep?	☐ Yes ☐ No
10. Do you feel pain or weakness when you walk?	☐ Yes ☐ No
11. Has your ability to Balance well decreased?	☐ Yes ☐ No
12. Are your feet or hands cold, damp or wet frequently?	☐ Yes ☐ No
13. Are you unable to sense your feet when you walk?	☐ Yes ☐ No
14. Is the skin on your feet so dry that it cracks open?	☐ Yes ☐ No
15. Have you ever suffered with nail fungus of the fingers or toes?	☐ Yes ☐ No

Diagnostic utility of the subjective peripheral neuropathy screen in persons with peripheral sensory polyneuropathy.

SCORE TOTAL YES ANSWERS _____ / 15

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Name: _____ DOB: _____ Date: _____

These questions ask about limitations to your walking due to peripheral neuropathy during the **past 2 weeks.** For each statement please circle the one number that best describes your degree of limitation. Please check that you have circled one number for each question.

In the past 2 weeks how much has your peripheral neuropathy…	Not at all	A little 25%	Moderately 50%	Quite a bit 75%	Extremely 100%
Limited your ability to walk?	**1**	**2**	**3**	**4**	**5**
Limited your ability to run?	**1**	**2**	**3**	**4**	**5**
Limited your ability to climb up or down stairs?	**1**	**2**	**3**	**4**	**5**
Made standing when doing things more difficult?	**1**	**2**	**3**	**4**	**5**
Limited your balance when standing / walking?	**1**	**2**	**3**	**4**	**5**
Limited how far you are able to walk?	**1**	**2**	**3**	**4**	**5**
Increased the effort needed for you to walk?	**1**	**2**	**3**	**4**	**5**
Made it necessary for you to use support when walking **indoors**, eg holding on to furniture, using a cane, etc?	**1**	**2**	**3**	**4**	**5**
Made it necessary for you to use support when walking **outdoors**, eg using a cane or walker, etc?	**1**	**2**	**3**	**4**	**5**
Slowed down your walking?	**1**	**2**	**3**	**4**	**5**
Affected how smoothly you walk?	**1**	**2**	**3**	**4**	**5**
Made you need to use more concentration when you walk?	**1**	**2**	**3**	**4**	**5**

WALKING SCALE QUESTIONAIRE SCORE TOTAL _____

DISABILITY SCORE: 12 NORMAL, 13-27 MILD, 28-45 MODERATE , >46 SEVERE DISABILITY

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