

Subjective Peripheral Neuropathy Screen Questionnaire

Full name: _____ Date _____

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Check **yes** or **no** based on how you usually feel. Thank you

1. Do you ever have legs and/or feet that feel numb? Yes No
2. Do you ever have any burning pain in your legs and/or feet? Yes No
3. Are your 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 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 tell the hot water from the cold water with your feet? Yes No
8. Do you ever have any sharp, stabbing, shooting pain in your feet or legs? Yes No
9. Have you experienced an asleep feeling or loss of sensation in your legs or feet? Yes No
10. Do you feel weak when you walk? Yes No
11. Are your symptoms worse at night? Yes No
12. Do your legs and/or feet hurt when you walk? 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 had electric shock-like pain in your feet or legs? Yes No