Merivale Chiropractic Clinic
460 West Hunt Club Rd.
Ottawa, ON K2E 0B8
613-226-8142

PERIPHERAL NEUROPATHY - Patient Introduction

Personal History:

Mr.__ Mrs.__ Miss__ Ms.__ Dr.__

First _____ Middle Ini._____ Last _____

Your Address: _____

City:_____ Prov:_____

Postal Code:_____

Telephone: Home:_____ Bus:_____

Cell:_____

Birth Date: (DD-MM-YYYY) _____-_____-_____ Age: _____ Male:_____ Female:_____

Occupation: _____Employer: _____

Marital Status:_____Spouse's Name:_____

Previous Chiropractor:_____City: _____

Last visit to this Chiropractor:_____

Reason for leaving: _____

Present MD:_____City: _____

Referred to our Centre by: _____

E-Mail: _____

☐ Check this box if we may contact you via email with our monthly newsletter, promotions, contests, and prizes.

☐ Would you or your workplace/common interest group benefit from a complimentary workshop on how to improve health and reduce injuries?

Merivale Chiropractic Clinic
460 West Hunt Club Rd.
Ottawa, ON K2E 0B8
613-226-8142

PERIPHERAL NEUROPATHY - Intensity Questionnaire

Full Name: _____ **Date:** _____

This questionnaire asks you about the intensity of symptoms in legs, feet & arms you may experience. Please provide answers based upon your experience of the symptoms in legs and feet over the period of the past week only. Thank you for helping.

1. How would you rate the discomfort in your legs, feet & arms?

Legs	Feet	Arms
☐ (4) Very severe	☐ (4) Very severe	☐ (4) Very severe
☐ (3) Severe	☐ (3) Severe	☐ (3) Severe
☐ (2) Moderate	☐ (2) Moderate	☐ (2) Moderate
☐ (1) Mild	☐ (1) Mild	☐ (1) Mild
☐ (0) None in the past week	☐ (0) None in the past week	☐ (0) None in the past week

2. How would you rate the restlessness in your limbs? (i.e. do you feel you need to keep moving around for relief?

Legs	Feet	Arms
☐ (4) Very severe	☐ (4) Very severe	☐ (4) Very severe
☐ (3) Severe	☐ (3) Severe	☐ (3) Severe
☐ (2) Moderate	☐ (2) Moderate	☐ (2) Moderate
☐ (1) Mild	☐ (1) Mild	☐ (1) Mild
☐ (0) None in the past week	☐ (0) None in the past week	☐ (0) None in the past week

3. How much relief do you get from moving around?

Legs	Feet	Arms
☐ (4) No relief	☐ (4) No relief	☐ (4) No relief
☐ (3) Mild relief	☐ (3) Mild relief	☐ (3) Mild relief
☐ (2) Moderate relief	☐ (2) Moderate relief	☐ (2) Moderate relief
☐ (1) Either complete or almost complete relief	☐ (1) Either complete or almost complete relief	☐ (1) Either complete or almost complete relief
☐ (0) No RLS symptoms to be relieved	☐ (0) No RLS symptoms to be relieved	☐ (0) No RLS symptoms to be relieved

4. How severe is your sleep disturbance due to your symptoms?

Legs	Feet	Arms
☐ (4) Very severe	☐ (4) Very severe	☐ (4) Very severe
☐ (3) Severe	☐ (3) Severe	☐ (3) Severe
☐ (2) Moderate	☐ (2) Moderate	☐ (2) Moderate
☐ (1) Mild	☐ (1) Mild	☐ (1) Mild
☐ (0) None in the past week	☐ (0) None in the past week	☐ (0) None in the past week

5. How severe was your tiredness or sleepiness during the day due to your symptoms?

☐ (4) Very severe
☐ (3) Severe
☐ (2) Moderate ☐ (1) Mild ☐ (0) None in the past week

6. How much does your condition impact your quality of life as a whole?

- ☐ (4) Very severe/ debilitating
- ☐ (3) Severe
- ☐ (2) Moderate
- ☐ (1) Mild
- ☐ (0) None in the past week

7. How often did you get symptoms?

Legs	Feet	Arms
☐ (4) Very often (6 to 7 days in 1 week)	☐ (4) Very often (6 to 7 days in 1 week)	☐ (4) Very often (6 to 7 days in 1 week)
☐ (3) Often (4 to 5 days in 1 week)	☐ (3) Often (4 to 5 days in 1 week)	☐ (3) Often (4 to 5 days in 1 week)
☐ (2) Sometimes (2 to 3 days in 1 week)	☐ (2) Sometimes (2 to 3 days in 1 week)	☐ (2) Sometimes (2 to 3 days in 1 week)
☐ (1) Occasionally (1 day in 1 week)	☐ (1) Occasionally (1 day in 1 week)	☐ (1) Occasionally (1 day in 1 week)
☐ (0) Never In the past week…	☐ (0) Never In the past week…	☐ (0) Never In the past week…

8. When you experienced symptoms, how severe are they on average?

Legs	Feet	Arms
☐ (4) Very severe (8 hours or more per 24 hour)	☐ (4) Very severe (8 hours or more per 24 hour)	☐ (4) Very severe (8 hours or more per 24 hour)
☐ (3) Severe (3 to 8 hours per 24 hour)	☐ (3) Severe (3 to 8 hours per 24 hour)	☐ (3) Severe (3 to 8 hours per 24 hour)
☐ (2) Moderate (1 to 3 hours per 24 hour)	☐ (2) Moderate (1 to 3 hours per 24 hour)	☐ (2) Moderate (1 to 3 hours per 24 hour)
☐ (1) Mild(less than 1 hour per 24 hour)	☐ (1) Mild(less than 1 hour per 24 hour)	☐ (1) Mild(less than 1 hour per 24 hour)
☐ (0) None in the past week	☐ (0) None in the past week	☐ (0) None in the past week

9. Overall, how severe is the impact of your symptoms on your ability to carry out your daily affairs, example carrying out a satisfactory family, home, social, school or work life?

- ☐ (4) Very severe
- ☐ (3) Severe
- ☐ (2) Moderate
- ☐ (1) Mild
- ☐ (0) None in the past week

10. How severe is your mood disturbance due to your symptoms; example angry, depressed, sad, anxious or irritable?

- ☐ (4) Very severe
- ☐ (3) Severe
- ☐ (2) Moderate
- ☐ (1) Mild
- ☐ (0) None in the past week

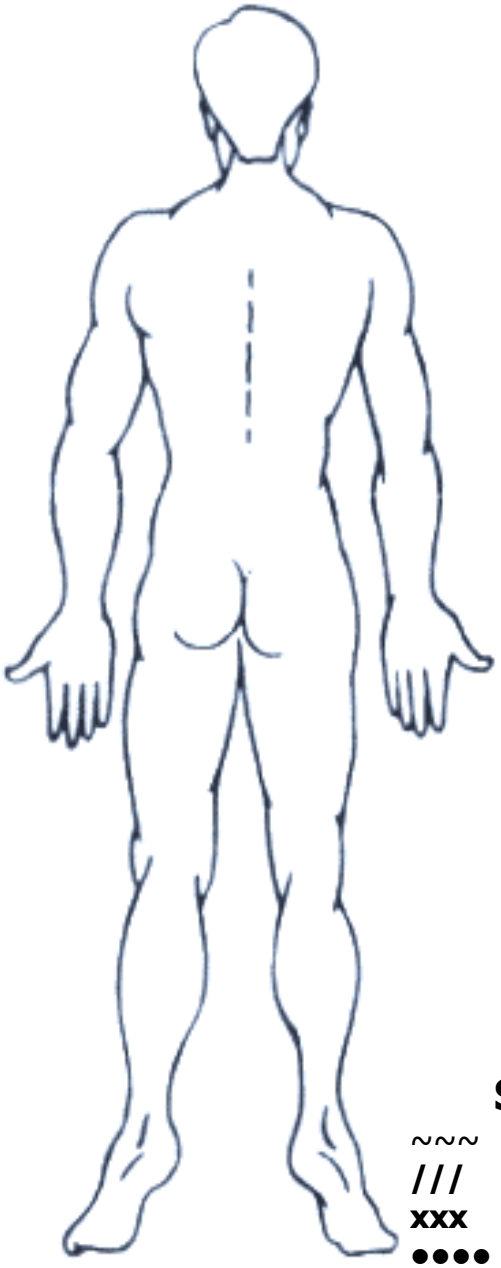
Thank you for completing this questionnaire

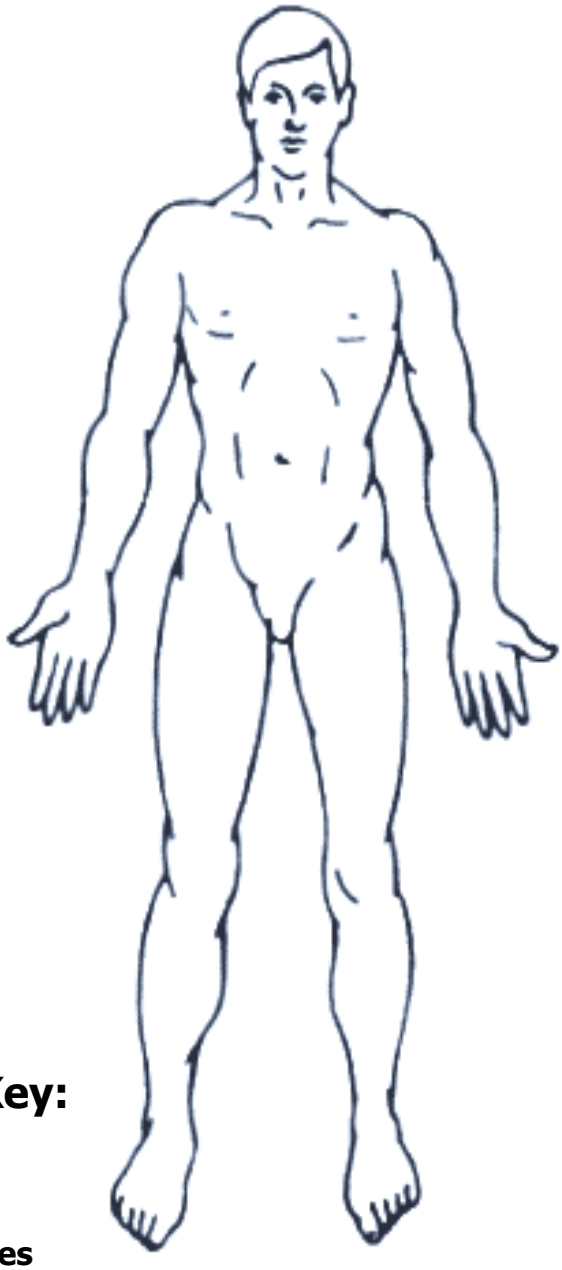
PERIPHERAL NEUROPATHY - Pain Drawing

Patient Name:_____

Date:_____

Please describe your current symptoms by marking on the drawing below, using symbols shown in the "Symptom Key", to indicate specific types of sensations.





Symptom Key:

~~	**Dull Ache**
///	**Shooting**
xxx	**Burning**
●●●●	**Pins & Needles**
○○○	**Other**_____