

## INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions and select which best fits for all of your answers.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Peripheral Nerves Intake		Yes	No	Pain Level													
				0	1	2	3	4	5	6	7	8	9	10			
1.	Do you have pain in your spine?	Yes	No														
2.	Do you have pain in your arms?	Yes	No														
3.	Do you have pain in your legs?	Yes	No														
4.	Do you have pain over your abdomen / torso?	Yes	No														
5.	Do you have weakness in your back?	Yes	No														
6.	Do you have weakness in your shoulders?	Yes	No														
7.	Do you have weakness in your hips or glutes?	Yes	No														
8.	Do you have weakness in your arms?	Yes	No		Mild		Moderate			Severe							
9.	Do you have weakness in your legs?	Yes	No		Mild		Moderate			Severe							
10.	Do you have weakness in your feet?	Yes	No		Mild		Moderate			Severe							
11.	Do you have weakness on one side of the body?	Yes	No		Mild		Moderate			Severe							
12.	Do you have cramping?	Yes	No		Mild		Moderate			Severe							
13.	Do you get weak with exercises or movement?	Yes	No		Mild		Moderate			Severe							
14.	Do your muscles cramp and freeze with movement?	Yes	No		Mild		Moderate			Severe							
15.	Do you have a loss in muscle size? Where: _____	Yes	No		Mild		Moderate			Severe							
16.	Have you noticed your muscles jumping? Where: _____	Yes	No		Mild		Moderate			Severe							
17.	Do you have weakness with your face?	Yes	No		Mild		Moderate			Severe							
18.	Do you have problems talking?	Yes	No		Mild		Moderate			Severe							
19.	Do you have problems swallowing?	Yes	No		Mild		Moderate			Severe							
20.	Do you have sensory loss or pain down your arm?	Yes	No		Mild		Moderate			Severe							
21.	Do you have sensory loss or pain down your leg?	Yes	No		Mild		Moderate			Severe							
22.	Do you have sensory loss on once side of the body?	Yes	No		Mild		Moderate			Severe							
23.	Do your have sensory loss over your shoulders?	Yes	No		Mild		Moderate			Severe							
24.	Do you have sensory loss with one arm or portion of the arm?	Yes	No		Mild		Moderate			Severe							
25.	Do you have sensory loss with one or both hands or a single finger? If so, which areas: _____	Yes	No		Mild		Moderate			Severe							
26.	Do you have bowel or bladder control issues?	Yes	No		Mild		Moderate			Severe							
27.	Do you have sensory loss over your abdomen or torso?	Yes	No		Mild		Moderate			Severe							
28.	Do you have pain or sensory loss over your hips?	Yes	No		Mild		Moderate			Severe							
29.	Do you have pain or sensory loss in one or both legs?	Yes	No		Mild		Moderate			Severe							
30.	Do you have sensory loss in your feet or a portion of your foot. If so where: _____	Yes	No		Mild		Moderate			Severe							
31.	Do you have sensory loss in your face? If so where: _____	Yes	No		Mild		Moderate			Severe							
32.	Do you have high arches?	Yes	No														
33.	Do you have hammertoes?	Yes	No														



# Peripheral Nerve Localization Form

## INSTRUCTIONS:

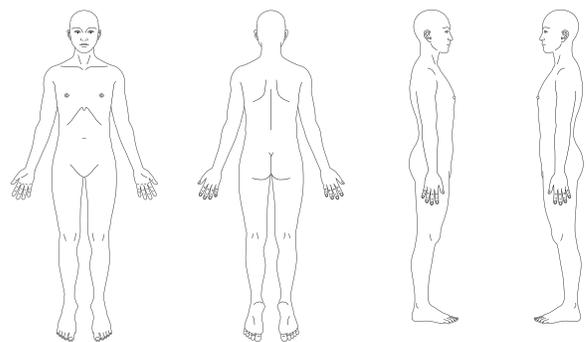
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NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Gait:		Yes	No	Pain Level		
1.	Do you fall frequently? How Often: _____	Yes	No			
2.	Do you have a hard time standing on your toes or heels?	Yes	No	Mild	Moderate	Severe
3.	Do you fall to one side?	Yes	No	Mild	Moderate	Severe
4.	Do you walk with your legs wide or far apart?	Yes	No	Mild	Moderate	Severe
5.	Do you waddle when you walk?	Yes	No	Mild	Moderate	Severe
6.	Do you have a hard time going up or down stairs?	Yes	No	Mild	Moderate	Severe
7.	Is one or both arms tight or spastic?	Yes	No	Mild	Moderate	Severe
8.	Is one or both of your legs spastic?	Yes	No	Mild	Moderate	Severe
9.	Do your feet slap when you walk?	Yes	No	Mild	Moderate	Severe
10.	Do you have to high step when you walk?	Yes	No	Mild	Moderate	Severe
11.	Do you shuffle when you walk?	Yes	No	Mild	Moderate	Severe
12.	Is it hard to start walking?	Yes	No	Mild	Moderate	Severe
13.	Is it hard to turn if you stop walking?	Yes	No	Mild	Moderate	Severe

### DOCTOR USE ONLY:



SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_