Peripheral Nerve Localization Form

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
1	Do you have pain in your spine?	Yes	No	0 1 2 3 4 7 8 9 10
2	Do you have pain in your arms?	Yes	No	0 1 2 3 4 7 8 9 10
3	Do you have pain in your legs?	Yes	No	0 1 2 3 4 7 8 9 10
4	Do you have pain over your abdomen/torso?	Yes	No	0 1 2 3 4 7 8 9 10
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 arms?	Yes	No	Mild Moderate Severe
21	Do you have sensory loss or pain down your legs?	Yes	No	Mild Moderate Severe
22	Do you have sensory loss on one side of the body?	Yes	No	Mild Moderate Severe
23	Do you 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 in 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	Mild Moderate Severe
33	Do you have hammertoes?	Yes	No	Mild Moderate Severe

	Gait Questionnaire:	Yes	No		Pain Level	
1	Do you fall frequently? How often: ___________________________	Yes	No	Mild	Moderate	Severe
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 a 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