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


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