Patient's Name:_____ **Date:**_____

CHEMOTHERAPY - INDUCED PERIPHERAL NEUROPATHY

Normal • Do you have any pre-existing peripheral neuropathy?	
Onset When did the symptoms begin?	
Provoking / Palliating What brings it on? What makes it worse? Better? Does it get better in-between tx?	
Quality (in last 24 hours) Can you describe it? • Sensory: numbness, tingling, pain, or burning • Motor: falls, tripping, muscle weakness, abnormal gait, or paralysis • Autonomic: constipation, urinary dysfunction, sexual dysfunction, orthostatic hypotension ○ Are symptom(s) intermittent or constant?	
Region / Radiation • Where are you experiencing your symptoms? (e.g. toes, fingers, symmetrical)	
Severity / Other Symptoms • How bothersome is this symptom to you? (on a scale of 0 – 10, with 0 not at all and 10 being the worst imaginable) • Are there any accompanying symptoms? (e.g. pain)	
Treatment • What medications or other strategies are you using right now? How effective? Side effects? • What medications or strategies have been effective in the past?	
Understanding / Impact on You • Do your symptoms affect your role function, mood or ability to do activities of daily living? (e.g buttoning shirt, writing, picking up small items) • Do your symptoms affect your ability to sleep (insomnia)?	
Value • What do you believe is causing	

this problem? What is your comfort goal or acceptable level for this symptom (0 – 10 scale)?	

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