

Neurotoxicity Checklist

Patient _____

Today's date _____ Date of last treatment _____

Since your last treatment...	No	Moderate	Moderate to Severe	Severe
Have you had new difficulty in buttoning/unbuttoning your shirt or putting on jewelry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been tripping or stumbling because of unusual or lost sensation in your feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had difficulty picking up small objects?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt pins and needles (electric sensation) or any unusual feeling at the tips of your fingers and toes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had trouble maneuvering around furniture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed an increased sensitivity to cold?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any of the above symptoms today?

Are you concerned or sad about the inability to do things you enjoy?

Shade the area(s) where you have experienced any discomfort, unusual sensations, or other changes.

