***1.* *When did you first notice symptoms?* \_­­\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_**

***2. With which hand do you write?*** ❑Right ❑Left ❑Both

***3. Describe how you noticed something was wrong and any events leading up to the onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***4. Antecedent events (within 6 weeks of symptoms):* Days before onset**

❑Strenuous Physical Activity \_\_\_d Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑Surgery \_\_\_d Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑Childbirth \_\_\_d ❑C-Section ❑Vaginal ❑Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑Infection/Acute Illness \_\_\_d ❑Respiratory ❑GI ❑Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑Recent Vaccination \_\_\_d ❑Influenza ❑Tetanus ❑Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑Trauma/Accident \_\_\_d Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_d Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***5. Was pain immediately present at onset?***

❑**Yes:**

1. Initial pain location(s) (please list and circle on Pain Body Map):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Pain began in the: ❑Morning (7-11:59 AM) ❑Afternoon (12-5:59 PM) ❑Evening (6-9:59 PM) ❑Night (10 PM-6:59 AM)
3. Pain Scale: \_\_\_/ 10
4. Quality of initial pain: ❑Burning ❑Throbbing ❑Achy ❑Dull ❑Sharp ❑Shooting ❑Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Progression of pain: ❑Sudden ❑Slowly intensifying
6. Has initial pain subsided? ❑Yes ❑No
7. If yes, how long did initial pain last? \_\_\_ days

❑**No:**

1. Have you experienced any symptoms of pain? ❑Yes ❑No ***(If no, skip to Question #6)***
2. Pain began within \_\_\_\_days of symptom onset
3. Pain Scale: \_\_\_/ 10
4. Quality of initial pain: ❑Burning ❑Throbbing ❑Achy ❑Dull ❑Sharp ❑Shooting ❑Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***6.* *Do you currently have pain?*** ❑Yes ❑No ***(If no, skip to Question #7)***

1. Pain Scale: \_\_\_/ 10
2. Quality of pain: ❑Burning ❑Throbbing ❑Achy ❑Dull ❑Sharp ❑Shooting ❑Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***7. Did you visit an urgent care or emergency room at the time of symptom onset?*** ❑Yes ❑No ***(If no, skip to Question #8)***

* 1. What was the diagnosis? ❑Parsonage-Turner syndrome ❑Cervical Radiculopathy ❑Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. Were any imaging tests performed? ❑Yes ❑No
  3. If so, what types? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***8.* *Do you have muscle weakness?*** ❑Yes ❑No

1. Weakness began within \_\_\_days of symptom onset

***9. Medications/Non-Drug Therapies (including those received in ED) Helped?* Y N Not Sure**

❑Corticosteroid Injections/IV ❑ ❑ ❑

❑Oral steroids (Prednisone) ❑ ❑ ❑

❑Prescription painkillers (e.g. Oxycodone, Tramadol®) ❑ ❑ ❑

❑NSAIDs (e.g. Ibuprofen, Naproxen, Aspirin, Toradol®) ❑ ❑ ❑

❑Intravenous Immunoglobulin (IvIg) ❑ ❑ ❑

❑Acetaminophen (Tylenol®) ❑ ❑ ❑

❑Gabapentin (Neurontin® ❑ ❑ ❑

❑Pregabalin (Lyrica®) ❑ ❑ ❑

❑Physical Therapy ❑ ❑ ❑

❑Acupuncture ❑ ❑ ❑

❑Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ ❑ ❑

***10. Have you experienced the following in addition to your symptoms of pain/weakness?***

Shortness of breath ❑Yes ❑No

Hoarseness/soft speech ❑Yes ❑No

Numbness ❑Yes ❑No

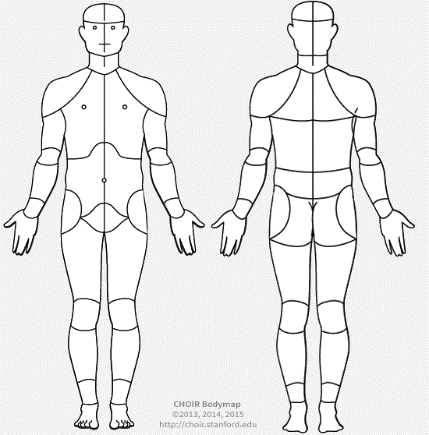
Tingling, prickling, or burning sensation ❑Yes ❑No

***11. Do you have a known separate medical condition to explain any symptoms you answered “Yes” to in #10?*** ❑Yes ❑No

1. If yes, specify:\_***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *12. Do you have a history of any of the following?* | | | | |
|  | **N** | **Y** | **Date of Diagnosis / Occurrence:** | **Additional Details:** | |
| Guillain-Barré syndrome | ❑ | ❑ | Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ |  | |
| Hepatitis E | ❑ | ❑ | Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ |  | |
| Lyme Disease | ❑ | ❑ | Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ |  | |
| Diabetes Mellitus | ❑ | ❑ | Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ | **Type I / Type II (Circle)** | |
| Autoimmune Disease | ❑ | ❑ | Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ | **Type:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Brachial Plexus Injury | ❑ | ❑ | Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ |  | |
| Other notable medical events or conditions: | ❑ | ❑ | Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ | **Type:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Pain Body Map**

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Thank you for your participation.