FOR STUDY USE ONLY. Please do not write in this section.

SITE ID: _____ INDIVIDUAL ID: _____

PHYSICIAN: _____ YEAR OF VISIT: _____
YYYY

PARTICIPANT HISTORY QUESTIONNAIRE

Read each question carefully and answer as thoroughly and accurately as possible. Some of these questions are sensitive in nature. If you are not comfortable answering any questions, you may skip the question. However, they are important assessments to evaluate the extent and severity of your symptoms associated with your peripheral neuropathy and, thus, important for our research.

If you are unsure how to fill out any part of this questionnaire, please do not hesitate to ask for help and guidance from the study team.

Section I. PARTICIPANT INFORMATION

a. What year were you born? _____

b. What is your sex? ☐ Male ☐ Female

c. Are you Hispanic or Latino? ☐ Yes ☐ No

d. What is your race? Mark only one.

☐ American Indian / Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ White
☐ Black or African American
☐ More than one race

e. Are you right- or left-handed? ☐ Right ☐ Left ☐ Ambidextrous

Section II. CURRENT SYMPTOMS

1. ONSET OF SYMPTOMS:

a. When did you notice the first symptoms associated with your peripheral neuropathy?

_____
(month / year)

b. What was your initial symptom associated with your peripheral neuropathy?

- ☐ Discomfort / Tingling
- ☐ Neuropathic pain
- ☐ Numbness
- ☐ Autonomic symptoms
- ☐ Muscle cramping
- ☐ Balance issues / falls
- ☐ Weakness
- ☐ Other: _____

2. PAIN: Do you have pain or painful discomfort from your polyneuropathy?

☐ Yes ☐ No ► If you do NOT have pain, skip to **Question 3 (on Page 6).**

a. When did you first experience neuropathic pain? _____
(month / year)

b. Where is your neuropathic pain located? Mark all areas that apply.

- ☐ Left foot
- ☐ Left lower leg (below knee)
- ☐ Left upper leg (knee and above)
- ☐ Left hand
- ☐ Left lower arm (below elbow)
- ☐ Left upper arm (elbow and above)
- ☐ Front of torso
- ☐ Back
- ☐ Right foot
- ☐ Right lower leg (below knee)
- ☐ Right upper leg (knee and above)
- ☐ Right hand
- ☐ Right lower arm (below elbow)
- ☐ Right upper arm (elbow and above)
- ☐ Face
- ☐ Neck

c. Do you also have lower back pain and neck pain?

☐ Lower back pain ☐ Neck pain ☐ No

I) If you have lower back pain, is it radiating into one or both legs?

☐ Not radiating ☐ Right leg ☐ Left leg ☐ Both legs

d. Which of the following statements describes your pain pattern the best? Please read all the options first before answering the question.

- ☐ Constant background pain with regular flare-up pain at distinct times of day (evening versus afternoon). If flare-up's can also be caused by activities, then check this box as well: ☐
- ☐ Constant background pain and flare-up pain due to activities (e.g. walking)
- ☐ Pain most intense when first getting out of bed
- ☐ Constant pain that does not vary much in intensity
- ☐ Occasional pain (sometimes pain, other times pain free)

For the next set of questions, place an "X" through the number that **best describes your background or constant pain.** If you have a prescription of neuropathic pain medication, **please describe your pain while taking your medication as prescribed.**

e. Please use the scale below to tell us how **intense** your background / constant pain is.

No Pain	0	1	2	3	4	5	6	7	8	9	10	*The most **intense** pain sensation imaginable*

f. Please use the scale below to tell us how **sharp** your background / constant pain feels. Words used to describe sharp feelings include "like a knife," "like a spike," "jabbing," "or like jolts."

Not sharp	0	1	2	3	4	5	6	7	8	9	10	*The **sharpest** sensation imaginable ("like a knife")*

g. Please use the scale below to tell us how **hot** your background / constant pain feels. Words used to describe very hot pain include "burning" and "on fire."

Not hot	0	1	2	3	4	5	6	7	8	9	10	*The **hottest** sensation imaginable ("on fire")*

h. Please use the scale below to tell us how **dull** your background / constant pain feels. Words used to describe very dull pain include "like a dull toothache," "dull pain," "aching," and "like a bruise."

Not dull	0	1	2	3	4	5	6	7	8	9	10	*The **dullest** sensation imaginable*

i. Please use the scale below to tell us how **cold** your background / constant pain feels. Words used to describe very cold pain include "like ice" and "freezing."

Not cold	0	1	2	3	4	5	6	7	8	9	10	*The **coldest** sensation imaginable ("freezing")*

j. Please use the scale below to tell us how **sensitive** your skin is to light touch or clothing. Words used to describe sensitive skin include "like sunburned skin" and "raw skin."

Not sensitive	0	1	2	3	4	5	6	7	8	9	10	*The most **sensitive** sensation imaginable ("raw skin")*

k. Please use the scale below to tell us how **itchy** your background / constant pain feels. Words used to describe itchy pain include "like poison oak" and "like a mosquito bite."

Not itchy	0	1	2	3	4	5	6	7	8	9	10	*The **itchiest** sensation imaginable ("like poison oak")*

For the next set of questions, place an "X" through the number that **best describes your flare-up pain. Describe the flare-up pain you experience while taking neuropathic pain medications.**

l. Please use the scale below to tell us how **intense** your flare-up pain is.

No pain	0	1	2	3	4	5	6	7	8	9	10	*The most **intense** pain sensation imaginable*

m. Please use the scale below to tell us how **sharp** your flare-up pain feels. Words used to describe sharp feelings include "like a knife," "like a spike," "jabbing," "or like jolts."

Not sharp	0	1	2	3	4	5	6	7	8	9	10	*The **sharpest** sensation imaginable ("like a knife")*

n. Please use the scale below to tell us how **hot** your flare-up pain feels. Words used to describe very hot pain include "burning" and "on fire."

Not hot	0	1	2	3	4	5	6	7	8	9	10	*The **hottest** sensation imaginable ("on fire")*

o. Please use the scale below to tell us how **dull** your flare-up pain feels. Words used to describe very dull pain include "like a dull toothache," "dull pain," "aching," and "like a bruise."

Not dull	0	1	2	3	4	5	6	7	8	9	10	*The **dullest** sensation imaginable*

p. Please use the scale below to tell us how **cold** your flare-up pain feels. Words used to describe very cold pain include "like ice" and "freezing."

Not cold	0	1	2	3	4	5	6	7	8	9	10	*The **coldest** sensation imaginable ("freezing")*

q. Please use the scale below to tell us how **sensitive** your skin is to light touch or clothing during flare-up pain. Words used to describe sensitive skin include "like sunburned skin" and "raw skin."

Not sensitive	0	1	2	3	4	5	6	7	8	9	10	*The most **sensitive** sensation imaginable ("raw skin")*

r. Please use the scale below to tell us how **itchy** your flare-up pain feels. Words used to describe itchy pain include "like poison oak" and "like a mosquito bite."

Not itchy	0	1	2	3	4	5	6	7	8	9	10	*The **itchiest** sensation imaginable ("like poison oak")*

s. Do you experience abnormal perceptions of pain or discomfort from a normally non-painful stimulus? For example, do you experience tingling, burning, discomfort or some other abnormal sensation when lightly touched or are hypersensitive to touch?

- ☐ Yes
- ☐ No
- ☐ Don't know

t. Are you taking medication or supplements for your neuropathic pain?

- ☐ Yes
- ☐ No ► If you do NOT take medication, skip to **Question 3 (Next Page).**

u. Which of the following statements best describes the effectiveness of your neuropathic pain medication (in comparison to not taking any medication for pain)?

- ☐ Not effective, no or minimal pain reduction
- ☐ Pain reduced, but remains very intense and unpleasant
- ☐ Pain reduced to tolerable level
- ☐ Effective, pain reduced to low level discomfort
- ☐ Very effective, pain no longer an issue until medication wears off

v. Does your pain medication have any side effects?

- ☐ Sleepiness, drowsiness (somnolence)
- ☐ Dizziness
- ☐ Weight gain
- ☐ Nausea, upset stomach
- ☐ Sexual dysfunction
- ☐ Other: _____
- ☐ No side effects

w. Have you ever used marijuana or CBD products such as smoking, consuming edibles, lotions, patches or creams to ease your neuropathic pain?

- ☐ Yes, I currently use marijuana (smoke, consume THC edible products, THC lotions, patches, etc)
- ☐ Yes, I currently use CBD containing products (edible products, lotions, creams, patches)
- ☐ Yes, I used them in the past, but currently do not use them
  - ► Why did you stop: _____
- ☐ No, I have never used marijuana products

y. Have you taken other medications or supplements for your neuropathic pain in the past?
If so, please tell us why you discontinued to take those medications:

Name of medication	Dosage of medication	Reason(s) you stopped / switched
		☐ Side effects ☐ Was never effective ☐ Effectiveness tapered off over time ☐ Insurance coverage ☐ Other:_____
		☐ Side effects ☐ Was never effective ☐ Effectiveness tapered off over time ☐ Insurance coverage ☐ Other:_____

z. Do you do any physical treatments to help with your neuropathic pain?

☐ Electrotherapy ☐ Massages
☐ Spinal cord stimulator ☐ Physical activities (e.g. stretching)
☐ Magnetic therapy ☐ Other: _____

3. LOSS OF SENSATION: Do you have loss of sensation (numbness)?

☐ Yes
☐ No ► If you do NOT have numbness, skip to **Question 4 (next page)**.

a. When did you first notice loss of sensation? _____
(month / year)

b. Where is your loss of sensation located? Mark all areas that apply.

☐ Left foot ☐ Right foot
☐ Left lower leg (below knee) ☐ Right lower leg (below knee)
☐ Left upper leg (knee and above) ☐ Right upper leg (knee and above)
☐ Left hand ☐ Right hand
☐ Left lower arm (below elbow) ☐ Right lower arm (below elbow)
☐ Left upper arm (elbow and above) ☐ Right upper arm (elbow and above)
☐ Front of torso ☐ Face
☐ Back ☐ Neck

c. Is your loss of sensation: (choose one)

☐ Always present ☐ Intermittent

For the following questions, please refer only to those symptoms you have experienced due to your peripheral neuropathy during the <u>past 7 days</u>.

d. When standing in the tub or shower and the water is only touching your feet, are you able to tell the difference between hot water and cold water?

☐ Yes

☐ No

e. Have you ever had an open sore not caused by physical injury on your feet?

☐ Yes

☐ No

4. Do you experience tight, painful contractions of your muscles? These are sometimes referred to as "cramps" or "charlie horse."

☐ Yes, daily or almost daily

☐ Yes, frequently (not daily, but at least once a week)

☐ Yes, sometimes (at least one a month, but less than once a week)

☐ Yes, but very rarely (less than once a month)

☐ No, never ► If you do <u>NOT</u> have painful contractions, skip to next question.

a. Are your tight, painful contractions of your muscles controlled with medications?

☐ Yes

☐ No, medication does not work

☐ I do not take medication for my muscle cramps

For the following questions, please refer only to those symptoms you have experienced due to your peripheral neuropathy during the <u>past 7 days</u>.

5. <u>BALANCE</u>: Do you have trouble with your balance or difficulties walking because of poor balance?

☐ Yes

☐ No ► If you do <u>NOT</u> have trouble with your balance, go to **Question 5b.**

a. When did you first notice balance issues? _____
(month / year)

b. Do you use any assistive devices when walking? Mark <u>all</u> that apply.

☐ Yes, I use shoe inserts ☐ Yes, I use a walker ☐ Yes, I use a cane
☐ Yes, I use ankle-foot orthotics ☐ Yes, I use a wheelchair
☐ Yes, I use walking poles ☐ No, I do not use any assistive devices

c. Have you had any falls in the past year?

☐ Yes, I had falls in the past year ► How many? _____
☐ No falls, but I had at least one near fall
☐ No, I have not fallen and had no near falls

6. <u>AUTONOMIC</u>: Now we want to know a little bit about your autonomic system. Your autonomic system regulates things like heart rate, blood pressure, sweating, bowel function, and sexual function.

a. Do you experience spells of lightheadedness or dizziness as if you were going to faint?

☐ Yes
☐ No ► If you do <u>NOT</u> have dizziness, go to **Question 6b**.

i. Do your spells of lightheadedness or dizziness get worse after the following activities? Mark <u>all</u> that apply.

☐ After standing up quickly ☐ After a hot bath or shower
☐ After standing for a long time ☐ After a large meal
☐ Other: _____

ii. Have you ever fainted or "passed out" in the past year?

☐ Yes, I have fainted in the past year. ► How many times? _____
☐ I have not fainted in the past year, but I have fainted in the past
☐ No, I have <u>never</u> fainted

b. Do you have abnormal sweating? Mark <u>all</u> that apply.

☐ Yes, I sweat <u>more</u> after eating
☐ Yes, I sweat <u>less</u> in a warm environment
☐ Yes, I have other abnormal sweating, please explain: _____
☐ No

c. Do you experience dryness of your eyes or mouth?

☐ Yes, dry eyes ► Do you have prescription medication for it? ☐ Yes ☐ No

☐ Yes, dry mouth ► Do you have prescription medication for it? ☐ Yes ☐ No

☐ No

d. Do you have frequently abnormal bowel movements (at least once a week)?

☐ Yes, I have frequent diarrhea

☐ Yes, I have frequent constipation

☐ No

e. Do you have difficulty with urination or increased urgency or frequency for urination, that is <u>not</u> caused by an enlarged prostate or another medical condition?

☐ Yes, I often experience a sudden, immediate need to go to the bathroom (urgency)

☐ Yes, I have the urge to go to the bathroom frequently (frequency)

☐ Yes, I lose control of my bladder (incontinence)

☐ Yes, I have trouble emptying my bladder or initiating urination

☐ No, I don't have difficulties with urination

f. In the past year, have you noticed color changes to your skin, such as red, white or purple?

☐ Yes, skin got redder / purplish

☐ Yes, skin got whiter

☐ No color changes

g. MEN ONLY: Has your sexual function changed recently? Mark <u>all</u> that apply.

☐ Yes, I have been having difficulties with erections

☐ Yes, I have been having difficulties with ejaculation

☐ No

7. <u>SLEEP</u>: Have you experienced sleeping difficulties?

☐ Yes

☐ No ► If you do <u>NOT</u> have sleeping difficulties, skip to **Question 8 (next page).**

a. Do you have difficulty falling asleep or staying asleep at night from pain due to your peripheral neuropathy?

☐ Yes ☐ No

b. Are your symptoms worse at night?

☐ Yes ☐ No

c. Do you have an urge to move your legs at night that is accompanied or caused by unpleasant sensations?

☐ Yes ☐ No

d. Are your sleeping difficulties controlled with medications?

☐ Yes

☐ No, medication does not work

☐ I do not take medication to treat my sleeping difficulties

8. Below is a list of common peripheral neuropathy symptoms. Please let us know how much each of those symptoms "bothers you" using the 0-10 scales below.

a. Neuropathic pain

0	1	2	3	4	5	6	7	8	9	10

Does not bother me *Extremely bothersome*

b. Discomfort in form of "tingling" or "pins and needles" sensations

0	1	2	3	4	5	6	7	8	9	10

Does not bother me *Extremely bothersome*

c. Loss of sensation (numbness)

0	1	2	3	4	5	6	7	8	9	10

Does not bother me *Extremely bothersome*

d. Weakness (loss of strength or power)

0	1	2	3	4	5	6	7	8	9	10

Does not bother me *Extremely bothersome*

e. Balance problems

0	1	2	3	4	5	6	7	8	9	10

Does not bother me *Extremely bothersome*

Section III: QUALITY OF LIFE

9. Below are some questions about how you feel and how things have been with you for the past four weeks. For each question, please give the answer that comes closest to the way you have been feeling

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep?	☐	☐	☐	☐	☐	☐
b. Have you been a very nervous person?	☐	☐	☐	☐	☐	☐
c. Have you felt so down that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
d. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
e. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
f. Have you been a happy person?	☐	☐	☐	☐	☐	☐
g. Did you feel tired?	☐	☐	☐	☐	☐	☐

10. During the past 4 weeks, how much of your time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good bit of time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

11. Do you experience pain when you are physically active?

☐ Yes ☐ No

12. Do your legs hurt when you walk?

☐ Yes ☐ No

Section IV. MEDICATIONS, VITAMINS, AND SUPPLEMENTS

Please list all medications, vitamins, and supplements that you are *currently* taking.

Medication, Vitamin, or Supplement	Dosage	Started taking
e.g., Aspirin	325 mg once a day	early 2020

Section V. MEDICAL HISTORY

13. Please mark all that apply and let us know if you were diagnosed before, after or about at the same time you noticed the first symptoms of peripheral neuropathy (PN):

	Before PN onset	After PN onset	Same time	Don't know
☐ Allergies	☐	☐	☐	☐
☐ Anxiety	☐	☐	☐	☐
☐ Amyloidosis	☐	☐	☐	☐
☐ Asthma	☐	☐	☐	☐
☐ Benign prostatic hyperplasia (BPH)	☐	☐	☐	☐
☐ Cardiac disease ► Please specify type of cardiac disease: ☐ Coronary artery disease ☐ Atrial fibrillation (arrhythmia) ☐ Heart attack ☐ Other: _____	☐	☐	☐	☐
☐ Cataracts (eyes)	☐	☐	☐	☐
☐ Celiac disease	☐	☐	☐	☐
☐ Cervical spine disease ► Location:_____	☐	☐	☐	☐
☐ Chronic fatigue syndrome	☐	☐	☐	☐
☐ Crohn's disease	☐	☐	☐	☐
☐ Depression	☐	☐	☐	☐
☐ Diabetes Mellitus (DM) ► Please specify type of DM ☐ DM Type 1 ☐ DM Type 2 ☐ Prediabetes	☐	☐	☐	☐
☐ Elevated cholesterol	☐	☐	☐	☐
☐ Elevated triglycerides	☐	☐	☐	☐
☐ Fibromyalgia	☐	☐	☐	☐
☐ Gastroesophageal reflex disease (GERD)	☐	☐	☐	☐
☐ Gout	☐	☐	☐	☐

	Before PN onset	After PN onset	Same time	Don't know
☐ Hepatitis ► Do you know which type of hepatitis ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ► Did you receive Interferon treatments? ☐ Yes ☐ No ☐ Don't know	☐	☐	☐	☐
☐ Herniated disk ► Location:_____	☐	☐	☐	☐
☐ Hypertension	☐	☐	☐	☐
☐ Irritable bowel disease	☐	☐	☐	☐
☐ Liver disease	☐	☐	☐	☐
☐ Long-term COVID	☐	☐	☐	☐
☐ Lumbar spine disease ► Location:_____	☐	☐	☐	☐
☐ Migraines	☐	☐	☐	☐
☐ Osteoarthritis	☐	☐	☐	☐
☐ Peripheral vascular disease	☐	☐	☐	☐
☐ Restless leg syndrome	☐	☐	☐	☐
☐ Rheumatoid arthritis	☐	☐	☐	☐
☐ Sarcoidosis	☐	☐	☐	☐
☐ Shingles	☐	☐	☐	☐
☐ Sjögren's syndrome	☐	☐	☐	☐
☐ Sleep apnea	☐	☐	☐	☐
☐ Thyroid disease ► Please specify type of thyroid disease ☐ Hyper ☐ Hypo ☐ Don't know	☐	☐	☐	☐
☐ Ulcerative colitis	☐	☐	☐	☐
☐ Vitamin B6 deficiency	☐	☐	☐	☐
☐ Vitamin B12 deficiency	☐	☐	☐	☐

14. Were you ever diagnosed with cancer?

☐ Yes ☐ No ☐ Don't know

► If yes, what type of cancer? _____

Did you receive chemotherapy? ☐ Yes ☐ No ☐ Don't know

► If you received chemotherapy, provide the names of the chemotherapy drugs:

_____

15. Do you have other medical or infectious conditions, not included in the list above? And when did they start in regard to your onset of peripheral neuropathy?

		Before PN onset	After PN onset	Same time	Don't know
1.	_____	☐	☐	☐	☐
2.	_____	☐	☐	☐	☐
3.	_____	☐	☐	☐	☐
4.	_____	☐	☐	☐	☐
5.	_____	☐	☐	☐	☐

16. If you have had <u>major</u> surgery, please list the type of surgery and when it was performed:

1. _____ Year of surgery: _____
2. _____ Year of surgery: _____
3. _____ Year of surgery: _____
4. _____ Year of surgery: _____
5. _____ Year of surgery: _____

Section VI. SOCIAL AND OCCUPATIONAL HISTORY

17. What is your current occupation? _____

18. What is your marital status?

☐ Single ☐ Widowed

☐ Married ☐ Divorced / Separated

19. Which best describes your living situation?

☐ I live alone.

☐ I live with my spouse / partner

☐ I live with relatives / roommate

20. Have you had (now or in the past) any occupational exposure to hazardous chemicals? Mark <u>all</u> that apply.

☐ Yes ► If YES, which one(s)? _____

☐ No

---

21. Have you <u>ever</u> smoked?

☐ Yes, I <u>currently</u> smoke

► **If YES,** When did you **<u>start</u>** smoking (year/age)? _____

AND how many cigarettes/packs do you smoke per day? _____

☐ Yes, I have smoked <u>in the past</u>

► **If YES,** when did you **<u>start</u>** smoking (year/age)? _____

AND when did you **<u>stop</u>** smoking (year/age)? _____

AND how many cigarettes/packs did you smoke per day?_____

☐ No, I never smoked.

---

22. Do you currently drink alcohol or have drunk alcohol in the past, and how many drinks do/did you consume per week? *For this question, one drink is equal to one glass of wine, one bottle of beer, or one mixed drink.*

☐ Yes, I <u>currently</u> drink

► **If YES,** how many drinks **<u>per week</u>?** _____

☐ Yes, I have drunk alcohol <u>in the past</u>

► **If YES,** how many drinks **<u>per week</u>?** _____

► **AND** what age did you stop drinking alcohol? _____

☐ No

Section VII. FAMILY HISTORY

23. Do you have any blood-related family members with peripheral neuropathy or other neurological conditions?

☐ Yes

☐ No ► Skip to next question

☐ Don't know ► Skip to next question

Please tell us more about your family members with peripheral neuropathy. In the table below, list their relationship to you (e.g. maternal aunt), type of neuropathy or neurological condition, and the age at which they were diagnosed. *See example.*

Relationship to you	Type of neurological condition	Age at diagnosis
e.g., Maternal Grandmother	*Diabetic neuropathy*	*68*

24. Do you have any family members with the following diseases or conditions: DIABETES, HIGH TRIGLYCERIDES, HIGH CHOLESTEROL?

☐ Yes

☐ No ► Skip to next question

☐ Don't know ► Skip to next question

Please tell us more about your family members with these diseases / conditions. In the table below, list their relationship to you, type of disease/ condition, and the age at which they were diagnosed with that disease or condition. *See example.*

Relationship to you	Type of disease/ condition	Age at diagnosis
e.g., Maternal Grandmother	*Diabetes AND High cholesterol*	*60*

Section VIII. EXERCISES

Please tell us about your exercise habits in the **past two weeks**. If you do not exercise on a regular basis, then please check this box**:**

☐ ***I do not exercise regularly***

Activity Type:	How many times in the past two weeks did you:	On average, how many minutes per occasion:	How intense would you rate the effort:
Aerobic Exercises			
Walking (for exercise) or hiking	Times	Minutes	□ Low □ Moderate □ High
Jogging or running (including treadmill)	Times	Minutes	□ Low □ Moderate □ High
Cycling, including stationary bike	Times	Minutes	□ Low □ Moderate □ High
Fitness classes (Barre, CorePower)	Times	Minutes	□ Low □ Moderate □ High
Water Aerobics	Times	Minutes	□ Low □ Moderate □ High
Swimming	Times	Minutes	□ Low □ Moderate □ High
Stairmaster	Times	Minutes	□ Low □ Moderate □ High
Thai Chi	Times	Minutes	□ Low □ Moderate □ High
Other: _____	Times	Minutes	□ Low □ Moderate □ High
Other:_____	Times	Minutes	□ Low □ Moderate □ High
Anaerobic Exercises			
Golf	Times	Minutes	□ Low □ Moderate □ High
Stretching	Times	Minutes	□ Low □ Moderate □ High
Yoga or Pilates	Times	Minutes	□ Low □ Moderate □ High
Weight lifting and weight training	Times	Minutes	□ Low □ Moderate □ High
Gardening and yard work	Times	Minutes	□ Low □ Moderate □ High
Other:_____	Times	Minutes	□ Low □ Moderate □ High

THANK YOU for filling out the PNRR Questionnaire!