RESTLESS LEGS SYNDROME QUESTIONNAIRE – CAREGIVER VERSION

Patient name: _____
Person filling out form: _____
Relation to patient: _____

1. Does the patient report "growing pains" or uncomfortable or funny feelings (creeping, crawling, tingling) in your legs?

___never
___ only in past
___ occasionally (<1x/month)
___ sometimes (1-2x/month)
___ frequently (1-2x/daily)

2. Does the patient appear restless while sleeping (thrashing around, banging feet against wall, twisting covers, or falling out of bed)?

___never
___ only in past
___ occasionally (<1x/month)
___ sometimes (1-2x/month)
___ frequently (1-2x/daily

3. Does the patient ever:	YES	NO	UNSURE
A. Notice funning feelings in your legs (or do they seem worse) when lying down or sitting?	____	____	____
B. Have partial relief with movement (wiggling feet, toes, or walking?)	____	____	____
C. Notice that the feeling is worse at night?	____	____	____
D. Have a lot of fidgeting or wiggling of your feet or toes when sitting or lying down?	____	____	____
E. Have repeated jerking movements in toes or legs or the whole body while sleeping?	____	____	____
F. Have a family member diagnosed with RLS? If so, what relation? _____	____	____	____