ROCHESTER Pain Management

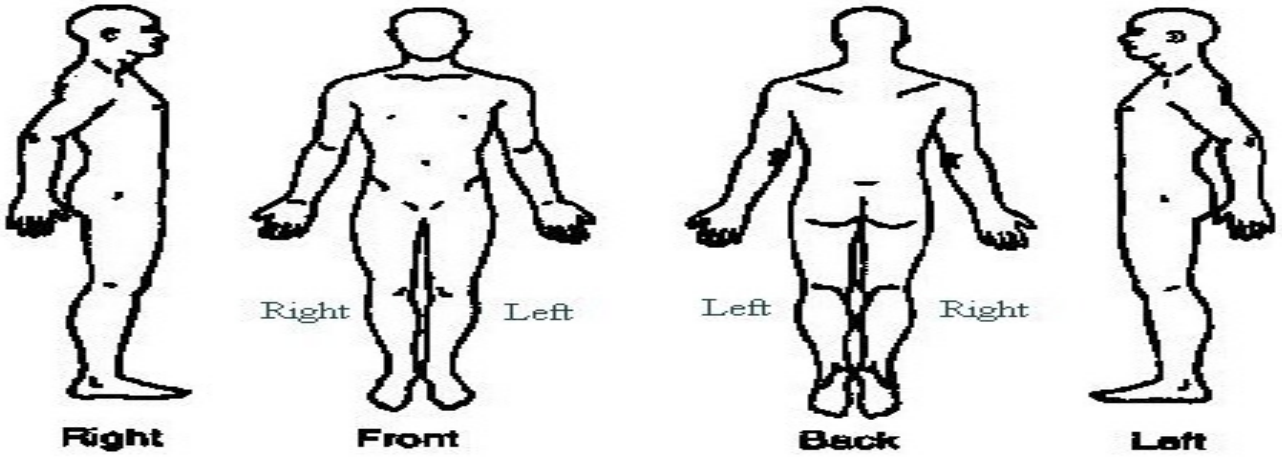
Tel: (585) 248-9170 Fax: (585) 248-9175

Name	Date of birth:
Referring physician:	Date of service:
Primary Care Physician:	

Please fill out this questionnaire and bring with you to your scheduled appointment. Be sure to include a list of all your medications and any x-rays/MRI imaging related to your pain.

On the pictures below, mark the areas that correspond with the descried sensation below.

Numbness 000 Pins-and-needles ΔΔΔ Burning xxxx Aching**** Stabbing //////



When did the pain begin? _____

Describe how your pain started *(for example: Accident, lifting, surgery, following an illness, or without any known cause);*

_____
_____
_____
_____
_____
_____

Circle all the words that describe your pain: Achy, burning, cramping, deep, dull, electrical shock, excruciating, numb, pressure, radiating, sharp, shooting, stabbing, throbbing, tingling, and other

_____

The Pain: __ comes and goes
__ constant

Since the beginning of the present problem, has the intensity of the pain:
__remained the same
__decreased
__increased

Is there any time during a course of 24 hours your pain is worse?

Does your pain interfere with falling asleep or maintaining of your sleep? If yes, please explain.

The following lines represent pain of increasing intensity for no pain (0) to very severe pain (10). Circled the number that best describes:

Your pain *right now*: 0 1 2 3 4 5 6 7 8 9 10
your *average* intensity of your pain this week: 0 1 2 3 4 5 6 7 8 9 10
your pain at its *highest*: 0 1 2 3 4 5 6 7 8 9 10
your pain at its *lowest*: 0 1 2 3 4 5 6 7 8 9 10

Is your pain associated with any or some the followings? Please circle if it applicable: Anger, anxiety, depression, fatigue, change in appetite, headache, sexual dysfunction, weakness, and bowel or bladder dysfunction.

***Aggravating factors: Circle all the words that make your pain worse*.** Anger, sitting, standing, bending, bowel movements, carrying, climbing stairs, driving, exercising, getting in and out of a car, intimate relations, neck movement, physical therapy, pulling, pushing, reclining, repetitious movement, lying down , sneezing, stooping, touching, turning over, walking, weather change and
_____

Alleviating factors: Circle all the words that make your pain better.
activity, acupuncture, chiropractic, emotional release, bending, bowel moment, deep breathing, heat, ice, lying down, massage, pain medications, physical therapy, position change, prayer, relaxation exercises, reclining, rest, sleeping, socializing, sitting, standing, stooping, stretching, walking. Or other, please specify:

Did you have the same type of pain in the past? If yes, *please explain what helped your pain*

Past pain medications:
Pain medications ***tried previously*** (please list the medications): Please explain if they helped or not. Please name over the counter medications if any.

_____
_____
_____
_____
_____

Current pain medications: Please list them and explain if they are helping your pain or not.
_____
_____
_____
_____
_____

Please describe if experienced side effects because of using pain medication(s)

Have you had any compliance issues with pain medications, if yes, please explain:

Have ever been referred or voluntarily sought consultation at chemical dependency clinic?

Have you had surgery or surgical consultation for your current pain condition?

Have you had Non pharmacologic approaches? If yes, please rate between 0 to 10 (0 being not effective at all, and 10 being very effective) on your overall pain and functions.

Acupuncture therapy_____ Massage therapy_____ Psychotherapy_____
Aqua therapy_____ TENS_____ Participation in support group_____
Biofeedback_____ Chiropractic care_____ Physical therapy_____
Self-hypnosis and biofeedback_____ Spinal cord stimulator trial or implant_____

Previous Evaluation for your current Pain:

Have you had any type of interventional therapy (pain injections) in the past for your current pain condition? If yes, please tell us the name of the injection and explain if the injection helped.

What studies have you had done (please Circle)?

Xray MRI CT Scan CT Myelogram Nerve Conduction study/EMG Blood Work Bone Scan

Results:_____
_____
_____
_____

Medication Allergies: include reactions to medications

Are allergic to Latex? (If yes, please describe the reactions)_____
Do you have food allergies (If yes, please list with reactions) _____
_____
_____

Current *medications:*

Medication	Dosage	How many per day	Reason for taking	Who prescribes

Past Medical History:

Past Surgical History: Please list the name all the surgeries that you had.

***Family History*: If any of your blood relatives has suffered from any of the following, please circle**

Rheumatoid Arthritis	Osteoarthritis	Diabetes	Bleeding Disorder	Heart Disease
Alcohol abuse	Blood disease	Chronic pain	Drug abuse	Glaucoma
High blood pressure	Migraines	Thyroid disease	Kidney disease	Suicide
Anxiety	Depression	Cancer(type)_____		

***Social history*:** marital status_____
Are you currently working: ***Circle One:*** full-time part-time retired disabled
What is the last day you worked: _____
Do you drink alcohol? _____ If yes, type and how often? _____
Are you a: current smoker non-smoker former smoker when did you quit_____
Do you use recreational drugs? _____ If yes, type and how often _____

Review of systems: (have you had any of these)conditions recently?

General/Constitutional
fatigue, fever, chills, lightheadedness, night sweats, weight gain, weight loss.

Allergy/Immunology

Immune deficiency, autoimmune disease, watery eyes, sneezing, and itching.
ENT
swollen glands, difficulty swallowing, hearing loss, ringing in the ears, vertigo
Endocrine
Diabetes, thyroid disease, menopause, pregnancy, hormone replacement
Respiratory
chest pain, cough, asthma, smoking, COPD, respiratory infection
Cardiovascular
chest pain with exertion, high blood pressure, Cardiac stent, Afib
Gastrointestinal
blood in stool, constipation, diarrhea, heartburn, nausea, vomiting. Abdominal pain
Genitourinary
blood in the urine, urinary tract infection, prostate disease
Musculoskeletal
joint stiffness, muscle aches, painful joints, muscle rigidity
Peripheral Vascular
pain/cramping in legs after walking, leg ulcer, poor circulation.
Skin
Skin color changes, sensitivity to touch. Skin texture changes, rash

Neurologic
balance difficulty, memory loss, and seizures. tremor. Loss of bowel or bladder control. Numbness, progressive weakness. headache
Psychiatric
anxiety, hallucinations, depression, mental or physical abuse, homicidal or suicidal thoughts.
Hematology
easy bruising, prolonged bleeding, use of blood thinner other than NSAIDS or low dose Aspirin
Ophthalmology:

Glaucoma, visual loss, double vision, cataract

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