ROCHESTER PAIN MANAGEMENT

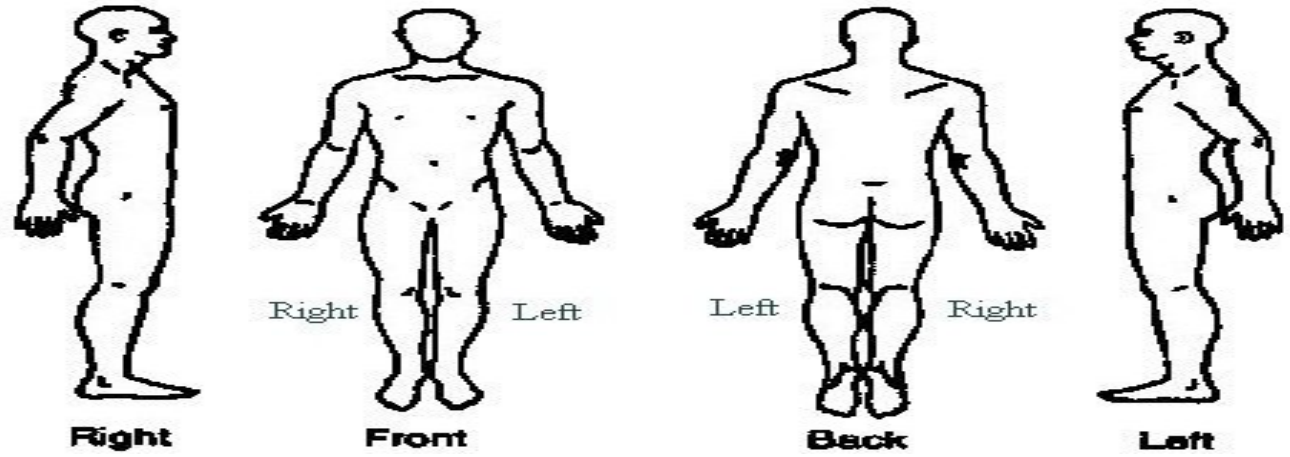
Rochester Pain Management, LLC.
200 Linden Oaks Drive, Suite 100
Rochester, NY 14625
(585) 248-9170 phone | (585) 248-9175 fax

Patient Name:	Date of Birth:
Referring Physician:	Date of Service:
Primary Care Physician:	Specialist Name: Dr.

Please fill out this questionnaire and bring with you to your scheduled appointment.

On the pictures below, mark the areas that correspond with the described sensation below:

Numbness **0000** Pins-and-needles **ΔΔΔΔ** Burning **xxxx** Aching********* Stabbing **//////**



Is your appointment related to a Worker Comp or Motor Vehicle accident injury? If so, please provide the date of injury and the body part injured _____
Not applicable ☐

When did the pain begin?

_____

_____

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

_____

_____

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Circle all the words that describe your pain:

achy	burning	cramping	deep
dull	electrical shock	excruciating	numb
pressure	radiating	sharp	shooting
stabbing	throbbing	tingling	

other: _____

Is the pain constant or does it comes and go?

Please explain:_____

_____

_____

Since the beginning of the present problem, has the intensity of the pain remained the same or increased or decreased?

Please explain:_____

_____

_____

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

Please explain:_____

_____

_____

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Does your pain interfere with falling asleep or maintaining of your sleep?

Please explain:_____

_____

_____

Have you had the same type of pain in the past? If yes, what helped your pain?

Please explain:_____

_____

_____

The following lines represent pain of increasing intensity; please rate with a number between **0 (no pain) to 10 (extreme pain)** for the 4 different scenarios.

Your pain *right now*: _____

Your *average* intensity of your pain this week: _____

Your pain at its *highest this week*: _____

Your pain at its *lowest this week*: _____

Is your pain associated with any or some the followings? Please circle all that apply:

Anger	Anxiety	Bowel or bladder dysfunction
Change in appetite	Depression	Fatigue
Headache	Sexual dysfunction	Weakness

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What makes your pain worse? Please circle all that apply

Anger	Bending	Bowel movements
Carrying items	Climbing stairs	Driving
Exercising	Getting in and out of a car	Intimate relations
Neck movements	Physical therapy	Pulling or pushing
Reclining	Repetitious movements	Sitting
Sneezing	Standing	Stooping
Touching	Walking	Weather change

Other: _____

What makes your pain feel better? Please circle all that apply.

activity	acupuncture	chiropractic
bending	bowel movement	deep breathing
emotional release	heat	ice
lying down	massage	pain medications
physical therapy	position change	prayer
relaxation exercises	reclining	rest
sleeping	socializing	sitting
standing	stooping	stretching
walking		

other:_____

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Have you undergone any non-pharmacologic approaches?
Please circle all that apply and rate between **0 to 10 (0 being not effective at all, and 10 being very effective)** on your overall pain and functions:

Acupuncture _____
Aqua (water) therapy _____
Biofeedback _____
Chiropractic care _____
Massage therapy _____
Participation in support groups _____
Physical therapy _____
Psychotherapy _____
Self-hypnosis _____
Spinal cord stimulation trial or implant _____
TENS unit _____
No other treatments done _____

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. Not applicable ☐

_____

_____

_____

_____

Have you had any imaging studies done in the past? Is so, where and when? (X-ray, MRI, Scan, CT, Myelogram, Nerve Conduction study/EMG, Bone Scan) **Not applicable** ☐

_____

_____

_____

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Patient Name:	Date of Birth:

Please list your current medications **If none, check here** ☐

Medication Name:	Dose:	Daily Amount:	Prescriber Name:

Please list any allergies to any medications and your reaction. If none, check here ☐

_____

_____

Are you allergic to Latex? If yes, please describe the reaction. **If none, check here** ☐

_____

_____

Do you have any food allergies? If yes, please list the food and the reaction.
If none, check here ☐

_____

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If you are currently taking any pain medication(s), please explain if they are helping your pain or the medication is not helping your pain. Please include any side effects of using the pain medication(s). If none, check here ☐

_____

_____

_____

_____

Please list any pain medications tried previously. Please explain if they helped your pain or the medication did not help. Please include any over the counter medications.
Please include any side effects of using the pain medication(s). If none, check here ☐

_____

_____

_____

Have you had any compliance issues with pain medications, if yes, please explain. If none, check here ☐

_____

_____

_____

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Have ever been referred or voluntarily sought consultation at chemical dependency clinic? If not, check here ☐

_____

_____

Have you had surgery or surgical consultation for your current pain condition?
If none, check here ☐

_____

_____

_____

Past Surgical History: Please list all surgeries, including the date of surgery
If none, check here ☐

_____

_____

_____

_____

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Patient Name:	Date of Birth:

Family History: Please circle any of the following conditions that apply to your blood relatives:

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

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Social history:

Marital status:

Circle One: Single Married Divorced Prefer not to answer

Are you currently working: Circle One:

Full-time Part-time Retired

Disabled (Date Disabled _____Percent of disability_____)

What is the last day you worked: _____

Do you drink alcohol? Yes No

If yes, what do you typically drink? _____

How often do you drink alcohol? _____

Do you smoke cigarettes or cigars? Yes No

Circle one: current smoker non-smoker former smoker

When did you quit? _____

Do you use recreational drugs? Yes No

If yes, type and how often? _____

Do you use medicinal marijuana? Yes No

If yes, how often? _____

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Personal Medical History **Do you have/or had any of the following** please circle ALL that apply

abdominal pain	anxiety	asthma	atrial fibrillation
autoimmune disease	balance difficulty	blood in stool	blood in urine
cancer _____		cataract	chest pain
chest pain with exertion	chills	constipation	COPD
cough	depression	diabetes	diarrhea/vomiting
difficulty swallowing	double vision	easy bruising	environmental allergies
fatigue	fever	glaucoma	headache
hallucinations	heartburn	hearing loss	high blood pressure
homicidal/suicidal thoughts	hormone replacement		immune deficiency
itching	joint stiffness	leg ulcer	lightheadedness
loss of bowel control	loss of urine control	memory loss	mental/physical abuse
menopause	muscle aches	muscle rigidity	nausea/vomiting
night sweats	numbness pain/cramping in legs after walking		
numbness in private regions	painful joints	poor circulation	pregnancy
prostate disease	progressive weakness	prolonged bleeding	rash
respiratory infection	ringing in the ears	seizures	sensitivity to touch
skin color changes	skin texture changes	sneezing	swollen glands
tremors	thyroid disease	urinary tract infection	
use of blood thinner (other than NSAIDs or low dose Aspirin)		vertigo	visual loss
weight gain	weight loss	other: _____	

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