ROCHESTER PAIN MANAGEMENT

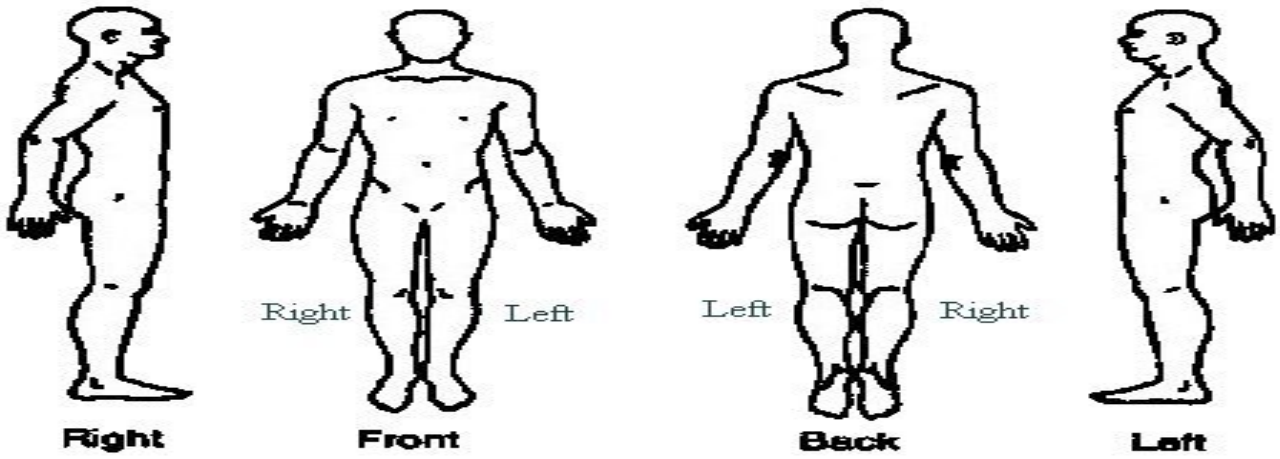
Rochester Pain Management, LLC.
200 Linden Oaks Drive, Suite 100
Rochester, NY 14625
(585) 248-9170 | (585) 248-9175

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. 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 described sensation below:

Numbness 0000 Pins-and-needles ΔΔΔΔ 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. _____

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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.* _____
_____
_____

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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 undergone any 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_____

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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 Name:	Dose:	Daily Amount:	Reason Taking:	Prescriber Name:

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***Past Medical History**: _____*
_____
_____
_____

***Past Surgical History:** Please list all surgeries that you have had, including the date*
_____
_____
_____

***Family History*:** *Please circle any of the following conditions that apply to your blood relatives:*
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 _____
Do you use Marijuana, either recreationally, or medicinally? Yes No

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Please circle if any condition below applies or has applied recently:

General/Constitutional
fatigue, fever, chills, lightheadedness, night sweats, weight gain, weight loss
Allergy/Immunology
immune deficiency, autoimmune disease, watery eyes, sneezing, 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, atrial fibrillation
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, seizures, tremors, loss of bowel/bladder control, numbness, progressive weakness, headache
Psychiatric
anxiety, hallucinations, depression, mental/physical abuse, homicidal/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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