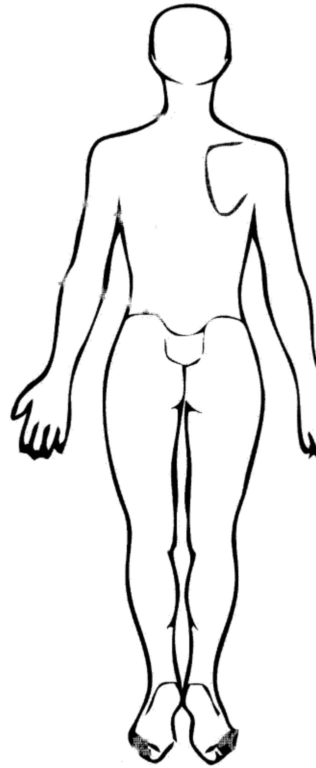
Rochester Pain Solution
300 Meridian Centre, Suite 305
Rochester, NY 14618
P (585) 491-6130 f (585) 491-6131

Patient Name		Date of Birth	
Referring Physician		Date of Service	
Primary Care Physician		Specialist Name	

Please fill out this questionnaire and bring it 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:

KEY	TYPE OF PAIN:	NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING	OTHER
	SYMBOL:	0000	AAAA	XXXX	****	////	####



Rochester Pain Solution
300 Meridian Centre, Suite 305
Rochester, NY 14618
P (585) 491-6130 f (585) 491-6131

When did the pain begin? ______________________________

Describe how your pain started ______________________________

Which words describe your pain:

☐	ACHY	☐	RADIATING
☐	BURNING	☐	SHARP
☐	CRAMPING	☐	SHOOTING
☐	DEEP	☐	STABBING
☐	DULL	☐	THROBBING
☐	ELECTRICAL SHOCK	☐	TINGLING
☐	EXCRUCIATING	☐	OTHER
☐	NUMB	☐	
☐	PRESSURE	☐	

Further describing your Pain
☐ Does it Come & Go?
☐ Is it Constant?

Since the beginning of the present problem, has the intensity of the pain:

☐ Remained the same	Comments:
☐ Decreased	Comments:
☐ Increased	Comments:

Is there any time, during the course of 24 hours, when your pain is worse? ☐Yes ☐No
Describe: ______________________________

Does your pain interfere with you falling asleep or maintaining your sleep? ☐Yes ☐No
Describe: ______________________________

Rochester Pain Solution
300 Meridian Centre, Suite 305
Rochester, NY 14618
P (585) 491-6130 f (585) 491-6131

The following lines represent your pain in increasing intensity from no pain (0) to very severe pain (10). Circle the number that best describes:

Your pain right now	0	1	2	3	4	5	6	7	8	9	10
The 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 of the following? ☐Anger, ☐ Anxiety, ☐ Depression, ☐ Fatigue, ☐ Changes in Appetite, ☐ Headache, ☐ Sexual Dysfunction, ☐ Weakness, and ☐ Bowel or Bladder Dysfunction
Describe:

Aggravating factors: Select 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
☐ Or other, please specify:

Alleviating factors: Select 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? ☐Yes ☐No
If Yes, Describe:

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

Rochester Pain Solution
300 Meridian Centre, Suite 305
Rochester, NY 14618
P (585) 491-6130 f (585) 491-6131

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

Please describe if you experienced any side effects due to the use of pain medication(s)
Describe:

Have you had any compliance issues with pain medications? ☐Yes ☐No
If yes, Describe:

Have you ever been referred or voluntarily sought consultation at a chemical dependency clinic? ☐Yes ☐No
If yes, Describe:

Have you had surgery or surgical consultation for your current pain condition? ☐Yes ☐No
If yes, describe:

Have you tried or undergone any of the following non-pharmacologic approaches to your pain management?
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	Dates Attended	Duration	0-1	2-3	4-5	6-7	7-8	9-10
Aqua Therapy			0-1	2-3	4-5	6-7	7-8	9-10
Bio Feedback			0-1	2-3	4-5	6-7	7-8	9-10
Self-Hypnosis and Bio Feedback			0-1	2-3	4-5	6-7	7-8	9-10
Massage Therapy			0-1	2-3	4-5	6-7	7-8	9-10
TENS			0-1	2-3	4-5	6-7	7-8	9-10
Chiropractic Care			0-1	2-3	4-5	6-7	7-8	9-10
Psychotherapy			0-1	2-3	4-5	6-7	7-8	9-10
Participation in a Support Group			0-1	2-3	4-5	6-7	7-8	9-10
Physical Therapy			0-1	2-3	4-5	6-7	7-8	9-10
Spinal Cord Stimulator Trial or Implant			0-1	2-3	4-5	6-7	7-8	9-10
Other: Describe			0-1	2-3	4-5	6-7	7-8	9-10

Has there been a previous evaluation for your current Pain: ☐Yes ☐No
If yes, describe:

Have you had any type of interventional therapy (like pain injections) in the past for your current pain condition?
☐Yes ☐No
If yes, please tell us the name of the injection and explain if the injection helped.

What studies have you done? Select from the following: ☐ Xray ☐ MRI ☐ CT scan ☐ CT Myelogram ☐ Nerve Conduction study ☐ EMG ☐ Blood Work ☐ Bone Scan
Results:

Rochester Pain Solution
300 Meridian Centre, Suite 305
Rochester, NY 14618
P (585) 491-6130 f (585) 491-6131

Do you have any Medication Allergies? ☐Yes ☐No
If Yes, List Medications and include any reactions experienced:

Are you allergic to latex? ☐Yes ☐No
If yes, please describe the reaction:

Do you have food allergies? ☐Yes ☐No
If yes, please list with reactions:

Current Medications: Please list your current medications and their prescriber and any relevant notes.

Medication Name	Dosage	Prescriber	Notes

Past Medical History: Please list your current and past medical history

Past Surgical History: Please list your current and past surgical history

Family History: Please select any of the following conditions that apply to you or your blood relatives

	Condition		Condition
☐	Rheumatoid Arthritis	☐	Chronic Pain
☐	Osteoarthritis	☐	Drug Abuse
☐	Diabetes	☐	Glaucoma
☐	Bleeding Disorder	☐	High Blood Pressure
☐	Heart Disease	☐	Migraines
☐	Alcohol abuse	☐	Thyroid Disease
☐	Blood Disease	☐	Kidney Disease
☐	Suicide	☐	Anxiety
☐	Depression	☐	Cancer

Rochester Pain Solution
300 Meridian Centre, Suite 305
Rochester, NY 14618
P (585) 491-6130 f (585) 491-6131

Social History
Marital status ☐ Single ☐ Married ☐ Separated/Divorced/Other

Are you currently working? Select one: ☐full-time ☐part-time ☐retired ☐disabled

Do you drink alcohol? ☐Yes ☐No
If yes, what, and how often do you drink?

Are you a: current smoker? ☐Yes ☐No
If yes, when did you quit?

Do you use recreational drugs? ☐Yes ☐No
If yes, type and how often

Do you use Marijuana, either recreationally, or medicinally? ☐Yes ☐No
If yes, describe

Lastly, we need to review your systems: If any of the conditions shown below apply (or have applied recently), please select them and provide any details.

General/Constitutional
☐ fatigue, ☐ fever, ☐ chills, ☐ lightheadedness, ☐ night sweats, ☐ weight gain, ☐ weight loss
Comments:

Allergy /Immunology
☐ immune deficiency, ☐ autoimmune disease, ☐ watery eyes, ☐ sneezing, ☐ itching
Comments:

ENT
☐ swollen glands, ☐ difficulty swallowing, ☐ hearing loss, ☐ ringing in the ears, ☐ vertigo
Comments:

Endocrine
☐ diabetes, ☐ thyroid disease, ☐ menopause, ☐ pregnancy, ☐ hormone replacement
Comments:

Respiratory
☐ chest pain, ☐ cough, ☐ asthma, ☐ smoking, ☐ COPD, ☐ respiratory infection
Comments:

Rochester Pain Solution
300 Meridian Centre, Suite 305
Rochester, NY 14618
P (585) 491-6130 f (585) 491-6131

Cardiovascular
☐ chest pain with exertion, ☐ high blood pressure, ☐ cardiac stent, ☐ atrial fibrillation
Comments:

Gastrointestinal
☐ blood in stool, ☐ constipation, ☐ diarrhea, ☐ heartburn, ☐ nausea, ☐ vomiting, ☐ abdominal pain
Comments:

Genitourinary
☐ blood in the urine, ☐ urinary tract infection, ☐ prostate disease
Comments:

Musculoskeletal
☐ joint stiffness, ☐ muscle aches, ☐ painful joints, ☐ muscle rigidity
Comments:

Peripheral Vascular
☐ pain/cramping in legs after walking, ☐ leg ulcer, ☐ poor circulation
Comments:

Skin
☐ skin color changes, ☐ sensitivity to touch, ☐ Skin texture changes, ☐ and rash
Comments:

Neurologic
☐ balance difficulty, ☐ memory loss, ☐ seizures, ☐ tremors, ☐ loss of bowel/bladder control, ☐ numbness,
☐ progressive weakness, ☐ headache
Comments:

Psychiatric
☐ anxiety, ☐ hallucinations, ☐ depression, ☐ mental/physical abuse, ☐ homicidal/suicidal thoughts
Comments:

Hematology
☐ easy bruising, ☐ prolonged bleeding, ☐ use of blood thinner (other than NSAIDs or low dose Aspirin)
Comments:

Ophthalmology
☐ glaucoma, ☐ visual loss, ☐ double vision, ☐ cataract
Comments: Associated with age mostly