Submit by Email | Print Form

Welcome!

The Pain Management Center and Dr. Theesfeld are pleased to participate in your pain management. As you know, pain affects many aspects of your life, and as such, several different tools will be used to evaluate and specifically identify the sources of your pain and suffering and how it interferes with your life. Your evaluation includes this Pain Questionnaire, initial and bi-annual Pain Patient Profile (a survey on how your pain affects your mental well being), sensory nerve testing when appropriate, the BBHI-2 (taken before and after treatment protocols) in an attempt to document the effects of treatment, and various radiological studies and including office based CT scans and video motion X-rays.

In order to best serve you, it is very important that you provide us with detailed information about you and your pain. This Pain Questionnaire has several parts and it will help us understand your pain problems. Please *print* your answers clearly so that they are easily read. Additionally, this Questionnaire may be repeated to update your medical files.

A. Please explain the history of your problem(s):

When did your pain first begin? _____
Where were you at the time your pain began? _____
What were you doing at that time? _____
Who did you first see for this? _____
What was your original diagnosis? _____
How much time passed between your injury and the beginning of your pain problems?
☐ Immediate Onset ☐ Hours ☐ Days ☐ Weeks ☐ Months
How is your pain different now, as compared to when it first started?

_____
What do YOU think is wrong? _____
Is this Workers Compensation? ☐ Yes ☐ No or a Personal Injury? ☐ Yes ☐ No
Have you obtained a lawyer for reasons related to your injuries? ☐ Yes ☐ No

B. Please describe prior treatments that you have had related to this problem:

Have you had spine surgery for your problem ☐ Yes ☐ No?
If yes; how many? _____ When was your last one? _____
Was your last surgery beneficial? ☐ Yes ☐ No
Please describe these surgeries. If more than 3, the first and last 2 will suffice.

Date of Surgery	Type of Surgery	Levels Involved	Name of Surgeon	Benefits Received

C. Treatment Survey: Mark “X” if attempted but NOT beneficial or “B” if taken and was beneficial.

	Epidural		Physical Therapy		Biofeedback		Massage Therapy
	Hypnosis		Chiropractic Care		TENS Unit		Trigger Point Injections
	Other						

D. Medication Survey: Mark X if taken but NOT beneficial or caused problems; B if taken and was beneficial.

	Ambien		Duragesic (Fentanyl)		Neurontin (Gabapentin)		Soma
	Anaprox		Effexor		Oxycodone		Sonata
	Arthrotec		Elavil (Amitriptyline)		Oxycontin		Ulram (Tramadol)
	Bextra		Flexeril		Paxil		Vicodin/Lorcet (Hydrocodone)
	Celebrex		Klonopin (Clonazepam)		Prozac		Wellbutrin
	Celexa		Methadone		Remeron		Zoloft
	Darvocet (Propoxyphene)		Mobic		Robaxin Skelaxin		

_____ _____
Patient’s Signature Today’s Date