

**Richard Bachrach DO, FAOASM
The Center for Sports and Osteopathic Medicine**

WELCOME!

In order to facilitate your care and our job, please complete ALL pages of this form. All information is personal and confidential and will not be disclosed to any third party without your consent..

Date:_____ Name:_____

Date of birth___/___/___ Social Security #:_____

Address: _____ City:_____ State_____

Zip:_____ E-Mail Address:_____

Home phone: (___) _____ Business (___) _____ Ext_____

Fax: (___) _____ Occupation _____ Employer _____

Insurance Carrier:_____

Referred By:_____

(F)___ (M)___ Single ___ Married ___ Domestic Partner ___ Divorced ___ Separated ___ Widowed ___

**THERE ARE 5 PAGES IN THIS QUESTIONNAIRE. PLEASE COMPLETE ALL OF THEM TO
THE BEST OF YOUR ABILITY.**

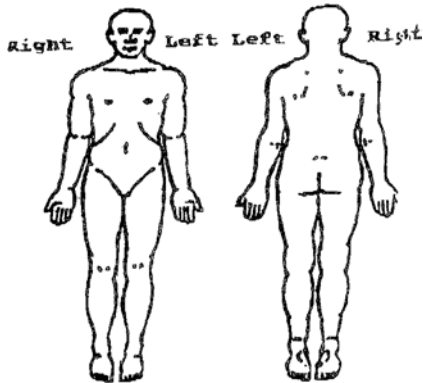
THANK YOU FOR ENTRUSTING US WITH YOUR CARE

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PAIN EVALUATION

Name: _____ Date: _____ 200

WHERE IS YOUR PAIN? (Please mark all painful areas on the diagram below **X**. No circles, hash marks, arrows, shading, etc. please.)



WHEN DID THIS (LATEST EPISODE) START? (Approximately) _____
WHAT DO YOU THINK HAPPENED TO CAUSE IT? _____

INTENSITY: (how bad is the pain? Circle the appropriate number: 0 = no pain; 10 = worst pain possible)

Now: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

PAIN CHARACTERISTICS: (check all that apply) Sharp ___ Dull ___ Burning ___ Aching ___
Pressure ___ Pins and Needles ___ Other _____

TIMING: constant? ___ Worse: morning? ___ afternoon? ___ evening? ___ night
awakening? ___

WHAT MAKES IT WORSE? Prolonged Sitting? ___ Lying down? ___ transitions? (Turning
over in bed, getting out of bed, sitting to standing, etc.) ___ prolonged standing? ___,
walking? ___ other? _____

WHEN DID THIS OR ANYTHING SIMILAR HAPPENED BEFORE? _____

TREATMENT? _____

OUTCOME? _____

1. Have you had any of the following tests for this or a similar problem? Fill in dates.
(approx): X-Ray? MRI? CT scan? Bone Scan?
Myelogram? Other? _____

2. Treatments for **this** problem?

Manipulation (osteopathic/chiropractic): When? _____ Result? _____

Medications: (types) _____ Result? _____

Injections: (types) _____ When? _____ Result? _____

Physical Therapy: ? _____ When? _____ Result? _____

Surgery? (types) _____ When? _____ Result? _____

3. Past Medical and Surgical History

List other medical problems (current & past) _____

List (ALL) surgeries with dates _____

List all current medications (including over the counter, non-prescription herbal and nutritional products and "recreational drugs" _____

List all allergies to medication: _____

4. Does anyone in your family have? Heart Disease? ___ Diabetes? ___
High Blood Pressure? ___ Cancer? ___ Back pain? ___ Nerve Disorder? ___ Arthritis?
Other? ___

5. Do you have or have you recently had any of the following? (circle)

Weight Loss? Gain? Chills? fever? Night pain? Numbness? Weakness? Bowel or bladder problems? Breathing problems? Other? _____

6. Social History: Smoker? No ___ Yes ___ Type? _____ Amount per day _____

Alcohol? How much? _____/day

Coffee, tea or other caffeinated beverages? How much? _____/day

Physical activity level? Weight training? Aerobics? Sports? Other? _____

How frequently? _____/week

Please use the back of this page for additional information or questions

**SKIP THIS PAGE IF YOUR PROBLEM DOESN'T RELATE TO YOUR
BACK**

Roland and Morris Disability Questionnaire

When your back hurts you may find it difficult to do some of the things you normally do. These are some sentences that people have used to describe themselves when they have back pain. When you read them you may find that some stand out because they describe **YOU TODAY**. As you read the list think of **YOURSELF TODAY**. When you read a sentence that describes **YOU TODAY**, circle **YES**. If that sentence does not describe **YOU TODAY**, circle **NO**. Remember only answer **YES** if you are sure that the sentence describes **YOU TODAY**.

- | | |
|---|-------|
| 1 I stay at home most of the time because of my back | Y / N |
| 2. I change position frequently to get my back comfortable | Y / N |
| 3 I walk more slowly than usual because of my back | Y / N |
| 4 Because of my back I am not doing any of the jobs that I usually do around the house. | Y / N |
| 5 Because of <i>my</i> back I use a handrail to get upstairs | Y / N |
| 6 Because of my back I lie down to rest more often | Y / N |
| 7 Because of my back I have to hold on to something to get out of an easy chair | Y / N |
| 8 Because of my back I try to get other people to do things for me | Y / N |
| 9 I get dressed more slowly than usual because of my back | Y / N |
| 10 I only stand up for short periods of time because of my back | Y / N |
| 11 Because of my back I try not to bend or kneel down | Y / N |
| 12. I find it difficult to get out of a chair because of my back | Y / N |
| 13. My back is painful almost all the time. | Y / N |
| 14. I find it difficult to turn over in bed because of my back | Y / N |
| 15. My appetite is not very good because of <i>my</i> back pain | Y / N |
| 16. I have trouble putting on my socks (or stockings) because of the pain in my back | Y / N |
| 17. I only walk short distances because of my back pain | Y / N |
| 18. I sleep less well because of my back | Y / N |
| 19. Because of my back pain I get dressed with help from someone else | Y / N |
| 20 I sit down for most of the day because of <i>my</i> back. | Y / N |
| 21. I avoid heavy jobs around the house because of my back | Y / N |
| 22. Because of my back pain I am more irritable and bad tempered with people than usual | Y / N |
| 23 Because of my back I go upstairs more slowly than usual | Y / N |
| 24 I stay in bed most of the time because of my back. | Y / N |

Score: Total of all items answered YES_____

Name: _____ Date: _____ 200

Please check-any item below you think may apply to you at any time in the past **TWO YEARS** and circle anything you would like to discuss

- | | |
|------------------------------------|--------------------------------|
| Faintness | Excessive worrying |
| Excessive fatigue | Frightening dreams, etc. |
| Dizziness | Sexual problems |
| Frightening thoughts | Extreme nervousness |
| Decisions difficult | Rages, temper tantrums |
| Memory loss or difficulty | Work problems |
| Inability to concentrate | Family problems |
| Depressed. hopeless outlook | Suicidal thoughts |
| Frequent crying | Shortness of breath |
| Loneliness | Weight loss/gain |
| Visual difficulties | Racing or irregular heart beat |

Urinary frequency: Day ____ Night ____ Urgency? ____ Incontinence ____

CURRENT:

Sleep Average ____ hrs/night; Difficulty getting to sleep? Y __ N ____

Sleep Medications? Y ____ N ____ What type(s) _____

Night awakenings? Y ____ N ____ How Many? ____ Night Pain? Y ____ N ____

How do you feel about your job? Great ____ Good ____ Fair ____ Terrible ____

Quality of your life: Great ____ Good ____ Fair ____ Terrible ____

Impact of your pain on family relationships _____

What do you expect from your care at the Center for Sports and Osteopathic Medicine? _____
