

**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 \_\_\_

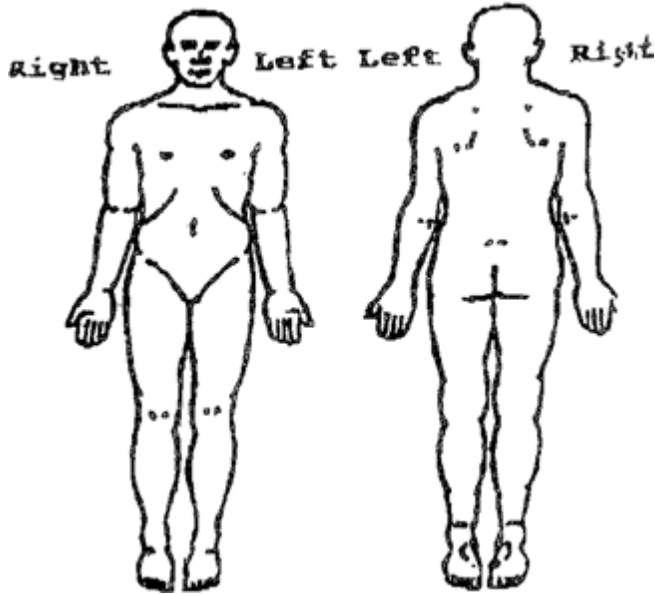
**THERE ARE 5 PAGES IN THIS QUESTIONNAIRE. PLEASE COMPLETE ALL OF THEM TO THE BEST OF YOUR ABILITY. THANK YOU FOR ENTRUSTING US WITH YOUR CARE**

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**PAIN EVALUATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**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, 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. Stay at home most of the time because of my back:                                     | Yes | No |
| 2. Change position frequently to get my back comfortable:                                | Yes | No |
| 3. Walk more slowly than usual because of my back:                                       | Yes | No |
| 4. Because of my back I am not doing any of the jobs that I usually do around the house: | Yes | No |
| 5. Because of <i>my</i> back I use <i>a</i> handrail to get upstairs:                    | Yes | No |
| 6. Because of my back I lie down to rest more often:                                     | Yes | No |
| 7. Because of my back I have to hold on to something to get out of an easy chair:        | Yes | No |
| 8. Because of my back I try to get other people to do things for me:                     | Yes | No |
| 9. Get dressed more slowly than usual because of my back:                                | Yes | No |
| 10. Only stand up for short periods of time because of my back:                          | Yes | No |
| 11. Because of my back I try not to bend or kneel down:                                  | Yes | No |
| 12. I find it difficult to get out of a chair because of my back:                        | Yes | No |
| 13. My back is painful almost all the time:  | Yes | No |
| 14. I find it difficult to turn over in bed because of my back:                          | Yes | No |
| 15. My appetite is not very good because of <i>my</i> back pain:                         | Yes | No |
| 16. I have trouble putting on my socks (or stockings) because of the pain in my back:    | Yes | No |
| 17. I only walk short distances because of my back pain:                                 | Yes | No |
| 18. I sleep less well because of my back:  | Yes | No |
| 19. Because of my back pain I get dressed with help from someone else:                   | Yes | No |
| 20. I sit down for most of the day because of <i>my</i> back:                            | Yes | No |
| 21. I avoid heavy jobs around the house because of my back:                              | Yes | No |
| 22. Because of my back pain I am more irritable and bad tempered with people than usual: | Yes | No |
| 23. Because of my back I go upstairs more slowly than usual:                             | Yes | No |
| 24. I stay in bed most of the time because of my back:                                   | Yes | No |

Score: Total of all items answered YES \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_