Bernard A. Rawlins, M.D.
NEW PATIENT INFORMATION FORM

Please print all information. All blanks must be filled to allow us to serve you quickly and efficiently. If you already completed this form in the last 2 months, please fill out just the first 2 pages and only items on other pages that have changed since your initial visit. Thank you for your cooperation.

Date: _____ Date of Birth: _____

Patient Name: _____
Address: _____
_____
Home Phone: ( )_____ Work: ( )_____

How were you referred to Dr. Rawlins: □ Physician □ Patient/ Friend

□ Insurance □ Other: _____

Referring Physician or Referral Source: _____

Address: _____

City, State:_____

Phone: ( )_____ Fax: ( )_____

Do you want your medical records sent to this physician/ referral source? □ Yes □ No

Primary Doctor: _____

Address: _____

City: _____

Phone: ( )_____ Fax: ( ) _____

Do you want your medical records sent to this physician? □ Yes □ No

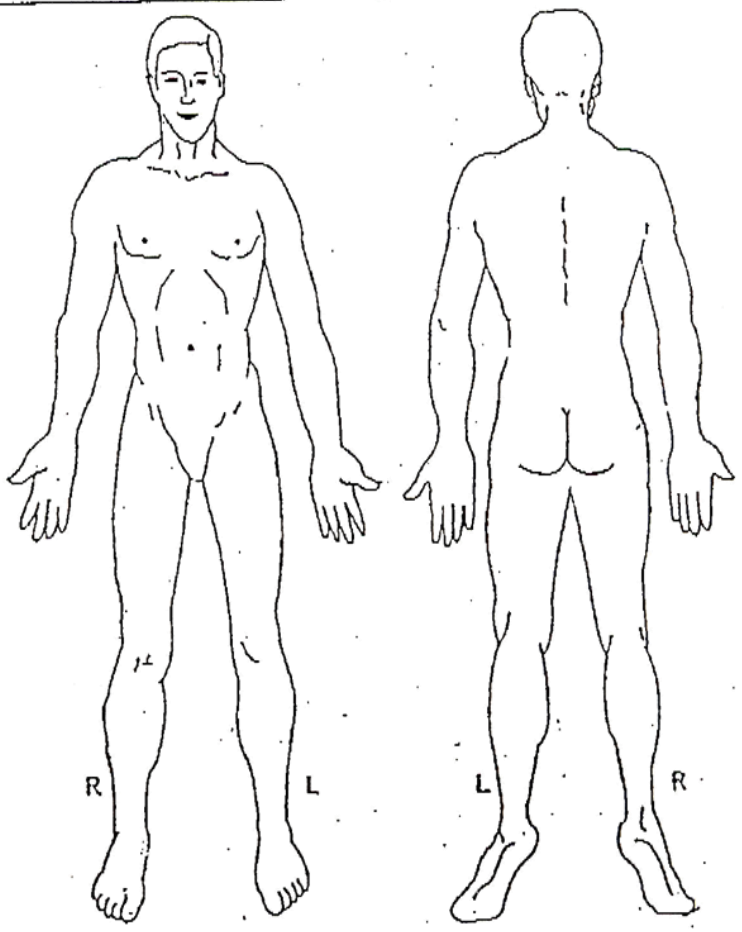
Are there any other physicians to whom you would like your medical records sent?
(Please include name and address)

_____
_____
_____

ORTHO PAIN CHART

Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

Numbness = = = = = = = = =	Pins & Needles = ooo ooo ooo	Burning xxx Aching = xxx xxx	Stabbing = //// //// ////



Please indicate your current pain level by placing a line below with "0"= no pain and "10" = worst pain imaginable.

Example: Pain
0 10

Pain on Average
0 10

Pain at its Worst
0 10

Pain at its Best
(lying down, resting) 0 10

HISTORY OF PRESENT COMPLAINT

1. Age: _____ ☐ Male ☐ Female

2. Where is your problem located? ☐ Neck ☐ Lower Back ☐ Arm ☐ Leg
☐ Right ☐ Left

3. How long have you had this problem? _____ Since? ____/ ____/_____
month day year

4. Briefly, please give the details of how this problem originally started:

_____

_____

_____

_____

5. Was this from a work-related injury? ☐ No ☐ Yes
Have you missed any work days because of this problem? ☐ No ☐ Yes, how much?_____

6. Please describe your present pain/problem now (what you feel, where, when, etc.):

_____

_____

_____

7. List all other physicians with whom you have consulted in the past year for this problem.

_____

8. Have you had spinal surgery in the past: (Check one) ☐ Yes ☐ No How many times?_____

What type of surgery(s) was/were performed? ☐ Discectomy ☐ Laminectomy ☐ Fusion

☐ Unknown ☐ Other _____ What spinal level? _____

What was the date of your most recent spine surgery? _____

Did you improve from your spine surgery procedure(s)? ☐ Yes ☐ No

9. Which of the following best describes the percentage of neck & arm or back & leg discomfort (if appropriate)

Back	Neck
A. 100% back pain and 0% leg pain	A. 100% neck pain and 0% arm pain
B. 90% back pain and 10% leg pain	B. 90% neck pain and 10% arm pain
C. 75% back pain and 25% leg pain	C. 75% neck pain and 25% arm pain
D. 50% back pain and 50% leg pain	D. 50% neck pain and 50% arm pain
E. 25% back pain and 90% leg pain	E. 25% neck pain and 75% arm pain
F. 10% back pain and 90% leg pain	F. 10% neck pain and 90% arm pain
G. 0% back pain and 100% leg pain	G. 0% neck pain and 100% arm pain

CURRENT PAIN PROFILE

10. Please choose letters A- F (in first column) to answer the questions in column two.

A. Unable to tolerate
B. About 15 minutes only
C. About 30 minutes only
D. About 45 minutes
E. About 1 hour
F. Indefinitely

How long can you sit? _____

How long can you stand? _____

How long can you walk? _____

11. Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Leaning forward (brushing teeth)	☐	☐	☐
Bending forward	☐	☐	☐
Lying on your side	☐	☐	☐
Lying on your back	☐	☐	☐
Lying on your stomach	☐	☐	☐
Rising from sitting	☐	☐	☐
Changing positions	☐	☐	☐
Coughing/ Sneezing	☐	☐	☐
Driving	☐	☐	☐

Now go back and CIRCLE the box to indicate the **most aggravating activity** and the **most relieving activity.**

12. Does your pain wake you up at night?

☐No ☐Yes ☐Daily ☐less than 3days/week ☐more than 3 days/week

13. If your pain has changed, please indicate the most appropriate statement: (Circle one)

A. My symptoms are **more** severe since the time of onset.
B. My symptoms have **remained the same** since the time of onset.
C. My symptoms are **less** severe since the time of onset.

14. Please indicate whether you have had any of the following studies and write year/where the most recent was:

	YES	NO	YEAR/WHERE
Regular X-ray of spine	☐	☐	_____
CT scan of spine	☐	☐	_____
MRI	☐	☐	_____
Myelogram	☐	☐	_____
Bone Scan	☐	☐	_____

15. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury: (Check one of each)

	Type/ Duration (weeks/ months)	Helpful	No Help	Not Used
Anti-inflammatory	_____	☐	☐	☐
Muscle Relaxants	_____	☐	☐	☐
Narcotic Pain Medications	_____	☐	☐	☐
Hot Packs	_____	☐	☐	☐
Ice	_____	☐	☐	☐
Ultrasound	_____	☐	☐	☐
TENS Unit/ Muscle Stim	_____	☐	☐	☐
Physical Therapy (Duration)	_____	☐	☐	☐
Back/ Neck Exercises	_____	☐	☐	☐
Chiropractor	_____	☐	☐	☐
Epidural Block/ Injection	_____	☐	☐	☐
Facet Block/ Injection	_____	☐	☐	☐
Trigger Point Injection	_____	☐	☐	☐
Acupuncture	_____	☐	☐	☐
Other:	_____	☐	☐	☐

Allergies	
Medication	**Reaction**

Current Medications	
Name	**Dose**

MEDICAL HISTORY

□ No medical problems	□ Diabetes	□ Bleeding disorders
□ High blood pressure	□ Thyroid disease	□ Anemia
□ Heart attack	□ Stomach ulcers	□ Blood clots in legs/ lung
□ Heart failure	□ Irritable bowel	□ Endometriosis
□ Abnormal heart rhythm	□ Stroke	□ Ovarian cysts
□ Lung disease	□ Seizures	□ Anxiety
□ Tuberculosis	□ Cancer – where? _____	□ Depression
□ Asthma	□ Kidney Failure	□ Schizophrenia
□ Bronchitis	□ Kidney Stones	□ Anorexia / bulimia
□ Emphysema	□ Osteoporosis	□ Alcoholism
□ Liver disease	□ Osteoarthritis	□ Seen a psychiatrist
□ Hepatitis	□ Rheumatoid arthritis	□ HIV

Are you under a doctor's care for any other medical condition? □ Yes □ No If yes, please explain

_____

SURGICAL HISTORY

Please choose all surgeries you have had

□ Spine- Neck	□Appendix / □ Intestine	□ Eyes
□ Spine- Lower back	□ Hernia / □ Colon / □ Rectum	□ Ears
□ Brain	□ Hysterectomy / □ C-section / □ Female	□ Nose
□ Heart	□ Kidneys / □ Bladder / □ Urinary	□ Throat/ □Tonsils
□ Angioplasty / □ Stent	□ Shoulders / □ Arms / □ Hands	□ Prostate
□ Lung	□ Hips / □ Knees / □ Legs / □ Feet	□Gallbladder/ □Stomach

Other: _____

_____

SOCIAL HISTORY

16. Martial Status: □ Single □ Married □ Divorced □ Widowed

17. Number of Children: _____

18. I live: □ Alone □ With: _____

□

19. Are you a cigarette smoker? Yes □ Never □ Quit – How long ago did you quit? _____

If you answered "yes" or "quit", how much do or did you smoke per day?

□ Less than ½ pack □1 pack □More (How many?) _____

20. Do you drink any alcoholic beverages? (Check one)

□ None □ 1 to 2 drinks per day □ Socially □ Occasionally

21. Current work status: □ Working full duty □ Working restricted duty (Since _____)

□ Retired □ Disabled (Since_____) □ Student □ Homemaker □ Unemployed

Company: _____ Occupation: _____ Title: _____

22. Have you ever had a problem with drug dependence? ☐ Yes ☐ No

23. Are there any law suits pending or contemplated related to your problem? ☐ Yes ☐ No

24. Please write any additional information that you feel is important for us to know.

_____

_____

REVIEW OF SYSTEMS

Please check off any current or recent problems you have

GENERAL
- ☐ Unexplained weight loss
- ☐ Appetite change
- ☐ Fevers or chills
- ☐ Night Sweats
- ☐ Marked fatigue
- ☐ Difficulty Sleeping

EAR, NOSE, THROAT
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Ear pain
- ☐ Nosebleeds

EYES
- ☐ Glasses
- ☐ Change of vision

CARDIOVASCULAR
- ☐ Heart or chest pain
- ☐ Abnormal heartbeat
- ☐ Poor heart function

LUNG
- ☐ Cough
- ☐ Shortness of breath

DIGESTIVE
- ☐ Nausea or vomiting
- ☐ Stomach pain or ulcers
- ☐ Heartburn
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Uncontrolled loss of stool
- ☐ Blood in stool
- ☐ Hemorrhoids

SKIN
- ☐ Frequent rashes
- ☐ Frequent itchiness
- ☐ Easy bruising
- ☐ Swollen ankles

NEUROLOGICAL
- ☐ Seizures
- ☐ Blackouts/ fainting
- ☐ Tremor
- ☐ Headaches/ migraines

MUSCULOSKELETAL
- ☐ Joint pains/ Swelling
- ☐ Muscle Aches

GENITOURINARY
- ☐ Burning on urination
- ☐ Difficulty starting urination
- ☐ Incontinence
- ☐ Pelvic pain
- ☐ Urinate at night more than once
- ☐ Unable to completely empty bladder

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Paranoia
- ☐ Obsessive / compulsive behavior