

**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

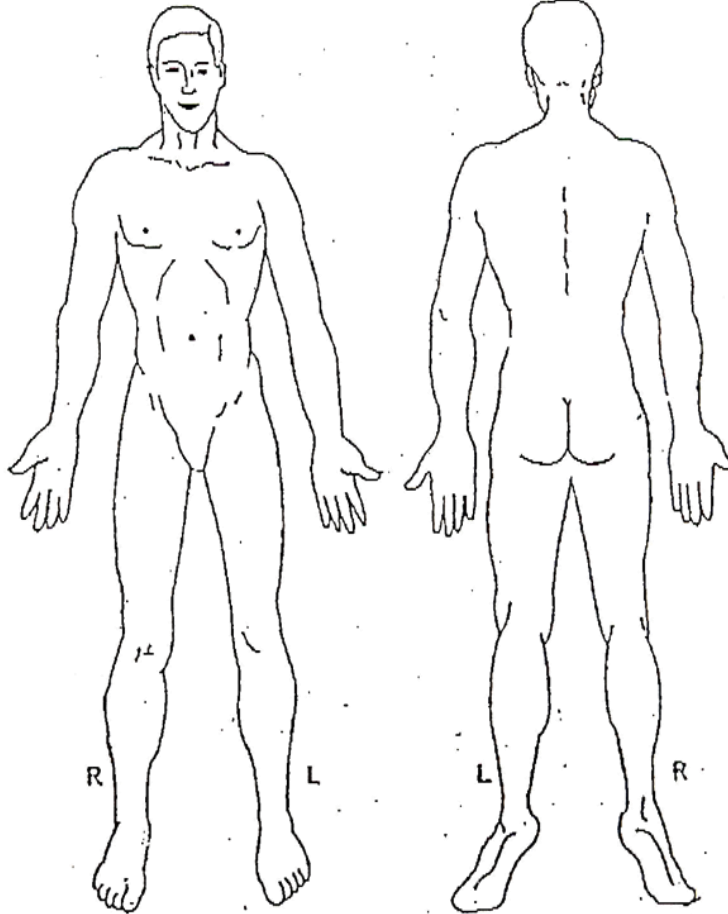
Are there any other physicians to whom you would like your medical records sent?  
(Please include name and address)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

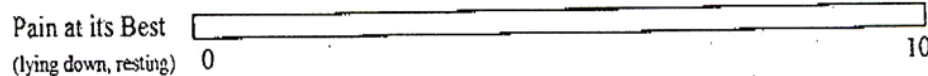
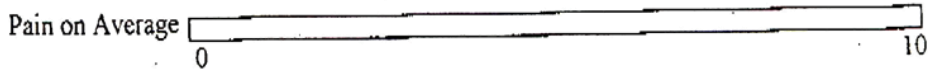
**ORTHO PAIN CHART**

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	Burning =	xxx	Stabbing =	////
	===		ooo	Aching =	xxx		////
	===		ooo		xxx		////



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



## **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)
- | <u>Back</u>                       | <u>Neck</u>                       |
|-----------------------------------|-----------------------------------|
| 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    | How long can you sit? _____   |
| B. About 15 minutes only |                               |
| C. About 30 minutes only | How long can you stand? _____ |
| D. About 45 minutes      |                               |
| E. About 1 hour          | How long can you walk? _____  |
| F. Indefinitely          |                               |

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

	Aggravates Pain	Relieves Pain	Neither
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaning forward (brushing teeth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/ Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT scan of spine	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Relaxants _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotic Pain Medications _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Packs _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit/ Muscle Stim _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy (Duration) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back/ Neck Exercises _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractor _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epidural Block/ Injection _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facet Block/ Injection _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trigger Point Injection _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Allergies	
Medication	Reaction

Current Medications	
Name	Dose

## MEDICAL HISTORY

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Spine- Neck                                  | <input type="checkbox"/> Appendix / <input type="checkbox"/> Intestine   | <input type="checkbox"/> Eyes  |
| <input type="checkbox"/> Spine- Lower back                            | <input type="checkbox"/> Hernia / <input type="checkbox"/> Colon / <input type="checkbox"/> Rectum                             | <input type="checkbox"/> Ears  |
| <input type="checkbox"/> Brain  | <input type="checkbox"/> Hysterectomy / <input type="checkbox"/> C-section / <input type="checkbox"/> Female                   | <input type="checkbox"/> Nose  |
| <input type="checkbox"/> Heart  | <input type="checkbox"/> Kidneys / <input type="checkbox"/> Bladder / <input type="checkbox"/> Urinary                         | <input type="checkbox"/> Throat/ <input type="checkbox"/> Tonsils      |
| <input type="checkbox"/> Angioplasty / <input type="checkbox"/> Stent | <input type="checkbox"/> Shoulders / <input type="checkbox"/> Arms / <input type="checkbox"/> Hands                            | <input type="checkbox"/> Prostate                                      |
| <input type="checkbox"/> Lung   | <input type="checkbox"/> Hips / <input type="checkbox"/> Knees / <input type="checkbox"/> Legs / <input type="checkbox"/> Feet | <input type="checkbox"/> Gallbladder/ <input type="checkbox"/> 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