NEW PATIENT INFORMATION SHEET

Dr. Robert Detch

Today's Date:

Patient Name:

MEDICAL HISTORY

Who referred you

Primary Care Physician

How did you hear about us? ◯ Physician ◯ Family ◯ Website ◯ Physical Therapist

Last Name | Mi | First Name | Prefered Name

DOB | WT | HT

Are you being treated for any medical diseases? (example: diabetes, osteoporosis, heart, lungs, ulcers, pulmonary emboli, high blood pressure)

1 | 3

2 | 4

Surgical History: Please list any surgeries or orthopedic injuries with approximate dates

1 | 3

2 | 4

Current Medications (list here or attach list)

1

2

Allergies to Medications:

1

2

Do you smoke? ◯ No ◯ Yes If yes, how many Packs per day?: Former Smoker?

Alcohol? ◯ Never ◯ Occasionaly ◯ Daily

History of bleeding disorders? ◯ No ◯ Yes

If Yes, Describe:

If there are any rare or unusual diseases in your family, please list:

1 | 3

2 | 4

Sports/Activities:

Currently working? ◯ No ◯ Yes If yes type of work:

PAIN DIAGRAM

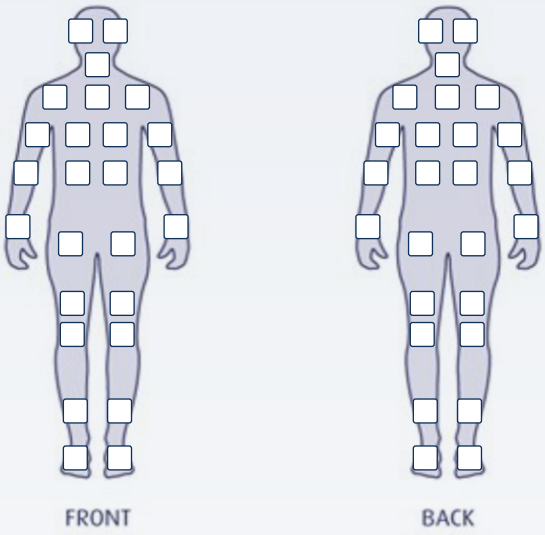
Patient Name: _____ Date: _____

Check the number that describes the severity of your pain:

No Pain ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ **Worst Pain**

Mark on the body outline areas where you feel the described sensations. *Use the appropriate symbol:*

Numbness	:	--- --- ---
Burning	:	xxx xxx xxx
Pins & Needles	:	ooo ooo ooo
Pain	:	/// /// ///



REVIEW OF SYSTEM

Please check any that apply:

Constitutional *Physician Comments*
- ☐ Fevers/ Chills/ Sweats
- ☐ Unexplained weight gain/ loss
- ☐ Excessive thirst or urination

Respiratory
- ☐ Cough/ Wheeze
- ☐ Difficulty breathing

Neurologic
- ☐ Headaches
- ☐ Dizziness/ Light Headedness
- ☐ Numbness
- ☐ Loss of Coordination

Skin/ Integument
- ☐ Eczema
- ☐ Rash

Hematologic/ Lymphatic
- ☐ Excessive Bleeding
- ☐ Easy Bruising

Endocrine
- ☐ Diabetes

Cardiovascular *Physician Comments*
- ☐ Chest Pain
- ☐ Palpitations

Gastrointestinal
- ☐ Blood in bowels
- ☐ Abdominal pain
- ☐ Nausea/ Vomiting
- ☐ Diarrhea

Mental Health
- ☐ Anxiety/ Stress
- ☐ Trouble Sleeping
- ☐ Depression

Genitourinary
- ☐ Incontinence
- ☐ Retention
- ☐ Recurrent UTI

Rheumatologic
- ☐ Rheumatoid arthritis

Other/ Not Listed:
- ☐ None Apply/ No Symptoms

Physician Signature: _____ Date: _____

I have reviewed and discussed this with the patient.