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. ____________________
2. ____________________
3. ____________________
4. ____________________

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

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Current Medications (list here or attach list)

1. ____________________
2. ____________________

Allergies to Medications:

3. ____________________
4. ____________________

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. ____________________
2. ____________________
3. ____________________
4. ____________________

Sports/Activities: ____________________

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

New Patient Information Sheet

PAIN DIAGRAM

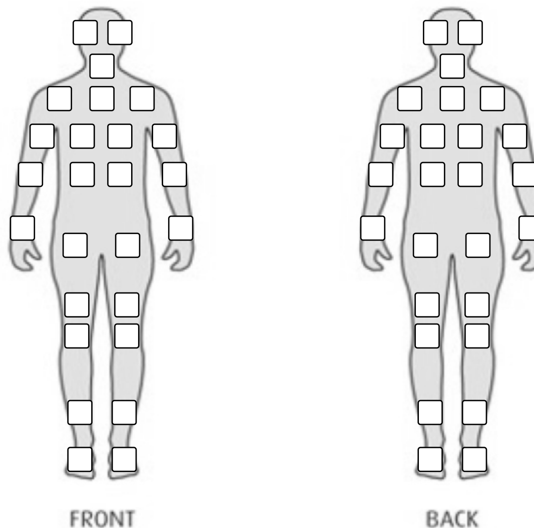
Patient Name: ______________________ MRN: __________ Date: ________

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: (if none apply, check the box indicating that none 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.