PHOENIX CHILDREN'S Medical Group®
(P) 602−933−3033 ❧ (F) 602−933−5245

NEW PATIENT SPORTS MEDICINE FORM

PCH SPORTS MEDICINE for YOUNG ATHLETES

Referral (please check):

☐ Physician: _____
☐ Emergency Department: _____
☐ Urgent Care: _____
☐ Physical Therapist: _____
☐ Athletic Trainer _____
☐ Friend: _____
☐ Web Site_____
☐ Other: _____

Primary Care Physician: _____

When did the problem first begin? _____

How did the injury occur? _____

What makes your condition worse? _____

Previous treatments? (i.e. physical therapy (location/duration), ice, rest, medications):

_____

_____

Past Medical History

Any major illnesses? _____

Previous operations? _____

Family Medical History

Health problems of parents, siblings: _____

Social History

School: _____ Grade: _____

Review of Systems (any problems with):

Constitutional (Fever, unexplained weight loss, masses)	☐ No	☐ Yes*
Eyes (Blurred Vision)	☐ No	☐ Yes*
Ear, Nose, Throat	☐ No	☐ Yes*
Cardiovascular System (Chest pain, shortness of breath)	☐ No	☐ Yes*
Respiratory System (Asthma, Cough)	☐ No	☐ Yes*
Neurologic System (Numbness, Tingling in arms or legs)	☐ No	☐ Yes*
Gastrointestinal system (Abdominal Pain, Nausea)	☐ No	☐ Yes*
Genitourinary System (Menstrual Irregularity, Urinary)	☐ No	☐ Yes*
Hematologic/Lymphatic (Anemia, Blood Disorders, Immune System)	☐ No	☐ Yes*
Endocrine System (Diabetes, Thyroid)	☐ No	☐ Yes*
Psychiatric (Depression, Anxiety)	☐ No	☐ Yes*
Allergic/Immunologic (Eczema, Hives, Recurrent Infections)	☐ No	☐ Yes*
Musculoskeletal	☐ No	☐ Yes*

*If you marked yes above, please explain problem in more detail here:

Physician Notes

_____ _____
Signature of Person Filling out form Date

_____ _____ _____
Practitioner's Signature Printed Name Date & Time