



www.phoenixchildrens.com/sports-medicine
(602) 241-0276

Today's Date: _____

Referral (please check):

- | | |
|--|---|
| <input type="checkbox"/> Physician: _____ | <input type="checkbox"/> Athletic Trainer _____ |
| <input type="checkbox"/> Emergency Department: _____ | <input type="checkbox"/> Friend: _____ |
| <input type="checkbox"/> Urgent Care: _____ | <input type="checkbox"/> Web Site _____ |
| <input type="checkbox"/> Physical Therapist: _____ | <input type="checkbox"/> Other: _____ |

Primary Care Physician: _____

Why are you being seen today? _____

When did the problem first begin? _____

Is the problem getting: worse better staying the same? (circle one)

Are you having pain? Yes No If yes, please describe the pain _____

What makes your condition worse? _____

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

Any Health Problems/Previous Injuries: _____

Previous Surgeries: _____

Family History (health problems of parents, siblings): _____

Social History:

School: _____ Grade: _____

Sports History:

Sport/Position/Level _____ Hours per week _____ Yrs Experience _____

Sport/Position/Level _____ Hours per week _____ Yrs Experience _____

Review of Systems (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Glasses | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Growth Changes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Poor Coordination |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Balance Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness in arms/legs |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Cough | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Behavioral problems | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Skin Rash/Eczema | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Eating/drinking problems |

Explain checked items:

Parent/Guardian Signature: _____ Date: _____

Imaging:

Assessment:

Plan:

RTC: _____

Attending Signature: _____