PCMC CONFIDENTIAL NEW PATIENT DATA SHEET
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TODAYS DATE:____________________

Name: _____________________________________ Birthdate: ____________________ Age: __________ Sex: M / F
Referred by: _______________________________ Physician Friend Therapist Other________________________

REASON FOR TODAY'S VISIT:

____

Is this the result of an injury? YES NO
Date of injury or of first symptoms: ______________ **How have they changed since then:** Better/Same/Worse
Location of symptoms: ______________________________ Left / Right / Both
If pain, is it: Continuous/Come and Go **Intensity of pain**: None 0 1 2 3 4 5 6 7 8 9 10 Intolerable
Nature of pain (circle all that apply): radiating / aching / burning / sharp / deep / stabbing / throbbing/shooting/clicks & pops
What makes your symptoms worse:____
What makes your symptoms better: ____
What things have you tried so far (i.e. Medication, injection, therapy, surgery, etc.):______________________________
What studies have you had so far (i.e. Xrays, CT, MRI, EMG, etc.):_____________________________________

MEDICAL HISTORY

Please list any *medical problems*: None
____
____
____

Please list *prior surgeries* (including dates): None
____
____
____

Allergies: None
____

Current Medications: None
____
____
____
____

Birth History:
Weight at Birth: ___________ **Born:** Full Term/Premature
Any Birth Problems:______________________________

Family History (Do any of the following run in the family?)

Cancer	Y / N	Stroke	Y / N
Heart Disease	Y / N	Diabetes	Y / N
Blood Clot	Y / N	Other__________________	

ACTIVITES / SPORTS / RECREATION

Recreational activities: ____
Sports Involved In:____
If sporting, at what level are you involved: Recreational Competitive Professional
Current Height: ___________ Current Weight: ________________
Grade in School:______________________

REVIEW OF SYSTEMS

Do you currently have any of these now or in the recent past (please circle):

Constitutional

Weight gain	Y / N
Weight loss	Y / N
Fatigue	Y / N
Trouble sleeping	Y / N

Respiratory Problems

Asthma	Y / N
Shortness of breath	Y / N
Persistent cough	Y / N

Cardiovascular

Heart murmur	Y / N

Joint problems

Rheumatoid arthritis	Y / N
Back pain	Y / N

Skin

Rashes	Y / N

Neurological

Numbness	Y / N
Stroke	Y / N

Gastrointestinal

Changes in bowel habits	Y / N
Reflux	Y / N
Digestion problems	Y / N
Change in stools	Y / N

Psychiatric

Depression	Y / N
ADHD	Y / N

Endocrine

Diabetes	Y / N
Hepatitis	Y / N

Genitourinary

Difficulty urinating	Y / N
Kidney stones	Y / N

Other

Sight impaired	Y / N
Hearing impaired	Y / N
Speech impaired	Y / N

Patient/Parent Signature: _______________________ Physician Signature: _______________________________