

SEACOAST ORTHOPEDICS & SPORTS MEDICINE

Marsh Brook Professional Center, 237 Route 108, Somersworth NH 03878 (603) 742-2007

INTAKE FORM REVIEWED with patient _____

Patient's Name (Please Print) _____ Date: _____

WORKERS' COMPENSATION INFORMATION

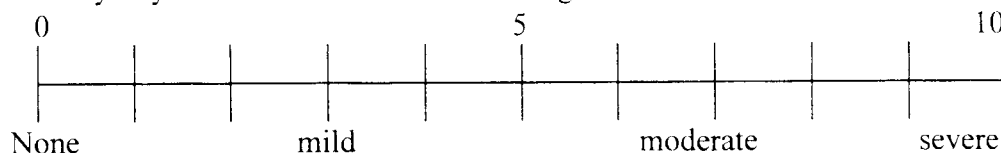
For what part of your body is the doctor seeing you **today**?

Date of Injury: _____ **How and where injury occurred:** _____

How would you describe your discomfort? (please circle all that apply):

Stabbing sharp achy burning constant intermittent
other _____

Please rate the severity of your discomfort on the following scale:



What makes your discomfort worse? (i.e., activity) _____

What makes your discomfort better? (i.e., medication, ice, rest) _____

DO YOU PARTICIPATE IN ANY ORGANIZED SPORT? Yes ___ No ___

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Family doctor/primary care physician: _____

Address: _____

Please list your email address if this is an acceptable mode of communication _____