

Name: _____ Date: _____
 What do you prefer to be called? _____ Age: _____ Height: _____ Weight: _____
 Circle: Right handed Left handed

Why are you seeing the doctor today? _____ **Right/Left** When did your symptoms start? _____
 Describe your injury or how your symptoms started: _____

 Have you ever had a similar problem before? No ___ Yes ___ If yes, explain: _____

 What are the symptoms keeping you from doing? _____

How would you describe your discomfort? (Circle all that apply)

Stabbing	Sharp	Achy	Burning	Throbbing
Constant	Intermittent	Shooting	Radiating	
Other: _____				

Rate your pain:

I _ I _ I _ I _ I _ I _ I _ I _ I _ I _ I

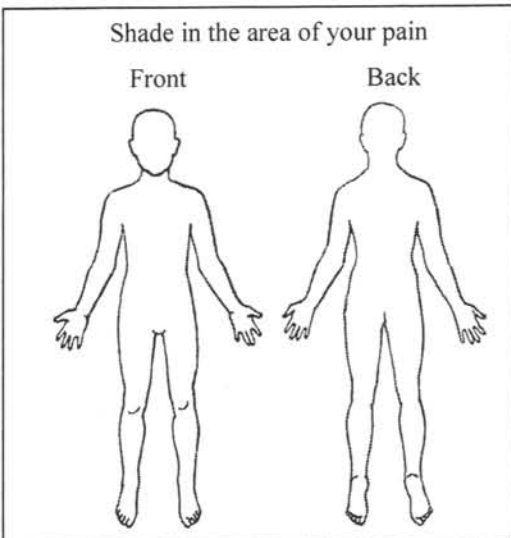
0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain ever

What makes your symptoms better? Ice Heat Stretching Pain reliever Rest Activity Other _____

 What makes your symptoms worse? Ice Heat Stretching Movement Weight bearing Other _____

Whom have you already seen for this? Primary Care ER / Urgent Care Trainer Chiropractor This is first evaluation
 Name of Family Doctor/Primary Care Physician: _____
 What tests have been done so far? X-ray MRI CT scan Bone scan Ultrasound Other _____
 What treatment have you had for this problem? Physical or occupational therapy Manipulation (osteopathic ± chiropractic)
 Medication Injection (Cortisone or other) None Other _____



Do you exercise regularly? Yes No How often? _____
 What do you do for exercise? Organized sports? _____

How did you hear about us? Referred by physician's office Newspaper Ad
 Radio Friend Yellow pages Internet/website
 Other _____

Intake form reviewed with patient: _____



7 Marsh Brook Drive, Somersworth NH
 Satellite Office: 65 Calef Hwy (Rte 125), Lee NH
 (603) 742 2007— (800) 429-5002
 www.sosmed.org



Name: _____ Date: _____

PAST MEDICAL HISTORY: (Please circle)

Briefly Explain:

- Ear, nose or throat problems
- Thyroid disease
- Heart disease (heart attack, angina, abnormal rhythm, heart failure)
- High blood pressure High cholesterol
- Lung problem (asthma, COPD)
- Abdominal problems (reflux, bowel disorder, ulcers)
- Liver disease (hepatitis, cirrhosis)
- Kidney disease
- Urinary or genital problems (enlarged prostate, UTI)
- Diabetes
- Skin problems
- Neurologic problems (seizures, tremors, stroke)
- Bone problem (osteoporosis, stress fx, bone infection, tumor)
- Anxiety, depression
- Blood clots, bleeding problems
- Cancer

LIST PREVIOUS SURGERIES:

A) Orthopedic (bones, joints, muscles, tendons): _____

B) Any other surgeries: _____

Allergies to medications: _____

Allergies to food, contrast dye, metal, latex, other: _____

Have you ever had a bad reaction to anesthesia? (If yes, briefly describe) _____

What medications do you take on a regular basis?

1. _____

2. _____

3. _____

4. _____

Please include supplements and herbal medications

5. _____

6. _____

7. _____

8. _____

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SIGNIFICANT FAMILY HISTORY: (circle)

Heart disease Stroke Diabetes Bone disorders Blood clots Pulmonary embolism Lung Disease
 Alcoholism Bad reaction to anesthesia Bleeding Disorders Cancer (type) _____
 Other: _____

SOCIAL HISTORY: (circle)

Employment: Occupation: _____ Student Retired Disabled
 Marital Status: Single Married Domestic partner Divorced Widowed
 Children? No Yes How many? _____
 History of substance abuse? No Yes What type? _____
 Smoke currently? No Yes If yes, _____ packs per day for _____ year(s)
 Quit smoking? No This year > 5 years ago > 10 years ago
 Alcohol consumption? Never Daily ___ # drinks/day ___ # times per week Rarely Recovering alcoholic
 Ambulatory capacity: Cane Crutches Walker Wheelchair No walking aids
 Who lives with you? Alone Spouse Partner Child(ren) Parent(s) Siblings Other: _____

Have you experienced any of these symptoms in the past month? (Circle all that apply)

SYSTEM		SYMPTOM EXAMPLES (Circle all that apply)
Constitutional	No	Unexpected weight loss, weight gain, fever, chills, fatigue
Eyes	No	Corrective lenses, blurred/double vision, eye pain, redness, watering
ENT (ears, nose and throat)	No	Headache, difficulty swallowing, nose bleeds, ringing in ears, earaches
Cardiovascular	No	Chest pain, palpitations, fainting, murmurs
Respiratory	No	Short of breath, wheezing, cough, tightness, inspiration pain, snoring
Gastrointestinal	No	Heartburn, nausea, vomiting, constipation, diarrhea, bloody/tarry stools
Genitourinary	No	Frequency, urgency, difficult/painful urination, flank pain, bleeding
Musculoskeletal	No	Joint pain, swelling, instability, stiffness, redness, heat, muscle pain
Skin/Integumentary	No	Skin changes, poor healing, rash, itching, redness
Neurologic	No	Numbness/tingling, unsteady gait, dizziness, tremors, seizures
Psychiatric	No	Nervousness, anxiety, depression, hallucinations, alcoholism
Hematologic/Lymphatic	No	Easy bleeding, bruising
Endocrine	No	Excessive thirst or urination, heat/cold intolerance

Intake form reviewed with patient: _____