

Name _____ Date of Birth _____ Today's Date _____

Current Complaint

Please check the area(s) of complaint:

- Head Shoulder Hip Face
- Neck Arm Leg Chest
- Upper Back Elbow Knee Ribs
- Mid Back Wrist Ankle Abdomen
- Low Back Hand Foot Flank

It developed from:

- Work-related activity
- Activity other than work
- Car accident (Date _____)
- An Injury (Date _____)
- Other _____

Describe the complaint:

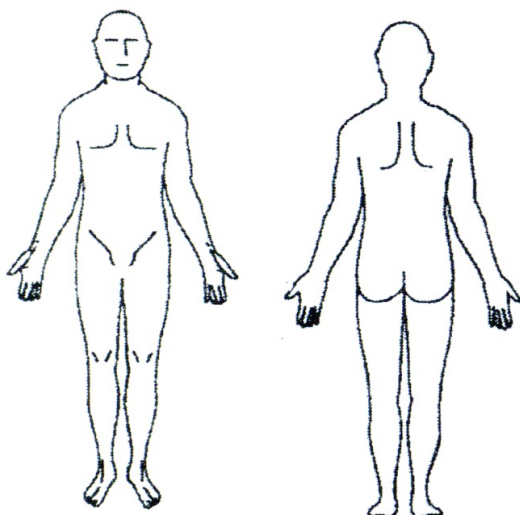
How did it happen?

Have you had this problem before? Yes No If yes, when? _____
 Have you seen other doctors for this complaint? Yes No
 If yes, name and contact of doctor _____

Please rate your ability to perform the following activities: √ = good x = difficult or impossible

- | | | |
|---|---|--|
| <input type="checkbox"/> coughing or sneezing | <input type="checkbox"/> bending over forward | <input type="checkbox"/> stooping |
| <input type="checkbox"/> getting in/out of car | <input type="checkbox"/> turning over in bed | <input type="checkbox"/> pushing |
| <input type="checkbox"/> bending forward to brush teeth | <input type="checkbox"/> sitting for >1hour | <input type="checkbox"/> pulling |
| <input type="checkbox"/> walking a short distance | <input type="checkbox"/> dressing yourself | <input type="checkbox"/> climbing stairs |
| <input type="checkbox"/> walking >1mile | <input type="checkbox"/> sexual activities | <input type="checkbox"/> reaching |
| <input type="checkbox"/> standing >1hour | <input type="checkbox"/> balancing | <input type="checkbox"/> gripping |
| <input type="checkbox"/> lying on your side w/ knees bent | <input type="checkbox"/> kneeling | <input type="checkbox"/> swimming |
| <input type="checkbox"/> lying flat on your back | <input type="checkbox"/> brushing your hair | <input type="checkbox"/> cycling |
| <input type="checkbox"/> lying flat on your stomach | <input type="checkbox"/> sleeping | <input type="checkbox"/> running |

Are you able to perform all of your regular employment duties? Yes No



Please indicate your areas of complaint:

- P = pain
- X = deep ache
- = tingling, pins, needles
- // = sharp, burning
- S = Spasm

Check other symptoms:

- Blurring vision
- Dizziness
- Headaches: how often? _____
- Weakness
- Numbness
- Loss of sleep
- Depression or crying spells
- Ringing in ears
- Loss of balance
- Fainting
- Bruising
- Swelling
- Redness

Past Health and Social History

Current health status _____ right handed left handed
Occupation _____ Marital status: S M D P W # of children _____
Family Physician _____ Phone _____
Other Physician(s) _____ Last Lab _____
_____ Last X-ray _____

(initial) *Dr. Holderegger may consult with the above physicians regarding my condition.*

List serious illnesses, fractures, surgeries or hospitalizations (date and explain)

List current medications	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

List previous work injuries or auto accidents

Circle and describe problems you have or have had in any of the following areas:

Skin	Lungs	Nerves	Blood	Ear/Nose/Throat
Head	Stomach/Bowel	Muscles	Hormones	Respiration
Heart	Urinary	Bones	Growth	Immunity

Please describe:

Do you have any blood relatives with a history of any of the following conditions? Relation? Age?	<i>Personal habits</i>	yes	no
Arthritis/Gout _____	Recent weight change	___	___
Cancer (type?) _____	Alcohol use	___	___
Heart attack _____	Recreational drug use	___	___
Stroke _____	Tobacco use	___	___
Other _____	Please describe: _____		

Do you have implants? Yes No (e.g. joint replacements, pins/screws, IUD, pacemaker)

Women: Are you pregnant? Yes No If yes, how far along? _____
Date of last menses _____

Signature _____