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? ____

____

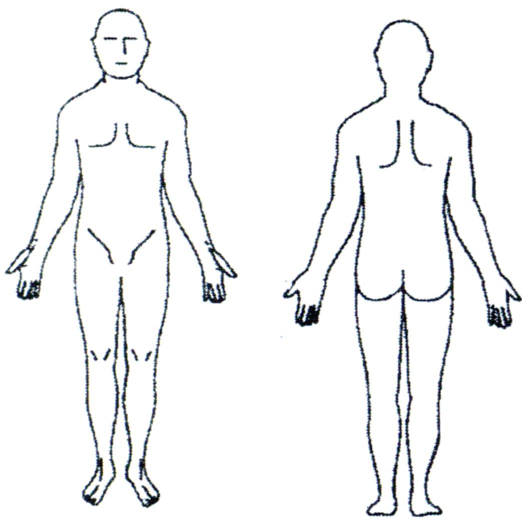
Have you had this problem before? ◻ Yes ◻ No If yes, when? _____________________
Have you seen other doctors for this complaint? ◻ Yes ◻ No
If yes, name and contact of doctor ____

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

__ coughing or sneezing	__ bending over forward	__ stooping
__ getting in/out of car	__ turning over in bed	__ pushing
__ bending forward to brush teeth	__ sitting for >1hour	__ pulling
__ walking a short distance	__ dressing yourself	__ climbing stairs
__ walking >1mile	__ sexual activities	__ reaching
__ standing >1hour	__ balancing	__ gripping
__ lying on your side w/ knees bent	__ kneeling	__ swimming
__ lying flat on your back	__ brushing your hair	__ cycling
__ lying flat on your stomach	__ sleeping	__ 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 ___________________________
_____ *Dr. Holderegger may consult with the above physicians regarding my condition.*
(initial)

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?

Arthritis/Gout ______________________
Cancer (type?) ______________________
Heart attack ______________________
Stroke ______________________
Other ______________________

Personal habits	yes	no
Recent weight change	___	___
Alcohol use	___	___
Recreational drug use	___	___
Tobacco use	___	___

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 ____