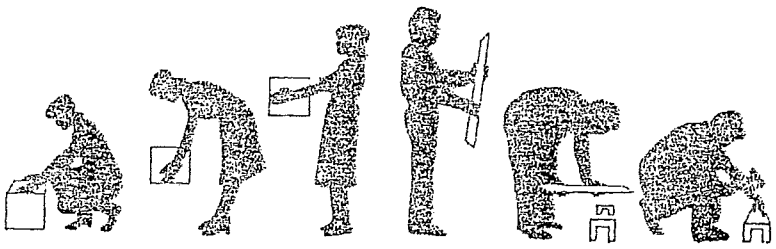
employee to fill out

IACOHC

International Academy of Chiropractic
Occupational Health Consultants

GENERAL HEALTH HISTORY QUESTIONNAIRE



GENERAL HEALTH HISTORY QUESTIONNAIRE

(Your Health Record is Treated as Confidential Material by Our Staff)

Date ____/____/____ Home Telephone # ____/____/____ Sex: Male ____ Female ____

Name: _____ Age ____ Birthdate ____/____/____
(First) (Initial) (Last)

Address _____ City _____ State ____ Zip Code _____

Marital Status: Single ___ Married ____ Divorced ____ Widowed ____ Separated ____ Height ____ Weight ____

Employer _____ Occupation _____ Full time ____ Part time ____

Telephone # at Work _____

What are your exact duties in your occupation? _____

How long have you worked for your present employer? _____ Years _____ Months _____ Weeks

If not presently employed, give the name of your most recent employer and your exact duties while working for this firm. _____

_____

How long did you work for your previous employer? _____ Year(s) _____ Months

Do you have a part-time job? ____ Yes ____ No Who is your employer for your part-time job? _____

_____ How many hours per week do you work at your part-time job? _____ Hours

Have you served in the military service? ____ Yes ____ No If yes, in which branch of the armed services did you serve? _____

If yes, what was your M.O.S. (military occupational status)? _____

Have you ever been rejected from military service because of health reasons or have you ever received a medical discharge from the military? ____ Yes ____ No If yes, what was the health problem that caused you to be discharged or rejected from the armed service? _____

Thank you for answering the following questions. A complete understanding of your health status will facilitate proper evaluation. Have you had any of the following illnesses? Check and give approximate date(s)

	Year		Year		Year		Year
Anemia	___ ____	Diphtheria	___ ____	Polio	___ ____	Whooping Cough	___ ____
Measles	___ ____	Hypertension	___ ____	Ulcer	___ ____	Migraine Headache	___ ____
Arthritis	___ ____	Emphysema	___ ____	Eczema	___ ____	Gallbladder Disease	___ ____
Smallpox	___ ____	Chickenpox	___ ____	Asthma	___ ____	Tumor or Cancer	___ ____
Pleurisy	___ ____	Malaria	___ ____	Colitis	___ ____	Heart Disease	___ ____
Stroke	___ ____	Diabetes	___ ____	Gout	___ ____	Diverticulitis	___ ____
Bursitis	___ ____	Tuberculosis	___ ____	Mumps	___ ____	Rheumatic Fever	___ ____
Pneumonia	___ ____	Rheumatism	___ ____	Hernia	___ ____	Venereal Disease	___ ____
Epilepsy	___ ____	Osteoporosis	___ ____	Typhoid Fever	___ ____	Kidney Disease	___ ____
Neuritis	___ ____	Hypoglycemia	___ ____	Scarlet Fever	___ ____	Bowel Obstruction	___ ____
Hay-Fever	___ ____	Encephalitis	___ ____	Thyroid Disease	___ ____	Alcoholism	___ ____
Hepatitis	___ ____	Meningitis	___ ____	Shingles	___ ____	Chemical Dependency	___ ____

Other(s) List: _____

Have you had surgery performed on any of the following:

	Year		Year		Year		Year
Stomach	___ ____	Ovaries	___ ____	Colon	___ ____	Uterus	___ ____
Rectum	___ ____	Gallbladder	___ ____	Thyroid	___ ____	Breast(s)	___ ____
Tonsils	___ ____	Appendix	___ ____	Hernia	___ ____	Prostate	___ ____

Other(s) List: _____

FAMILY HISTORY

Parents age: (if still living) Mother ____ Father ____ If deceased, give age at the time of death and the illness or accident which caused the death(s): Mother's age at expiration ____ cause of death _____

Father's age at expiration ____ cause of death _____

General health of parents: (If living) Father: ____ Excellent ____ Good ____ Fair ____ Poor

Mother: ____ Excellent ____ Good ____ Fair ____ Poor

Give the age of your siblings (brothers and sisters): _____

General health of your siblings ____ Excellent ____ Good ____ Fair ____ Poor

How many children do you have? _____ Ages of your children_____
Give the general health of your children ____ Excellent ____ Good ____ Fair ____ Poor
Has any member of your family had:

____ Arthritis	____ Family member(s) _____	____ Epilepsy	____ Family member(s) _____
____ Heart Disease	____ Family member(s) _____	____ Diabetes	____ Family member(s) _____
____ Hypertension	____ Family member(s) _____	____ Allergies	____ Family member(s) _____
____ Cancer	____ Family member(s) _____	____ Kidney Disease	____ Family member(s) _____

____ Nervous or mental disorder_____Family member(s)_____
____ Other serious diseases_____Family member(s)_____
Name of the disease(s) or disorder(s)

SYMPTOMS SURVEY

If you are having any of the following signs or symptoms of illness at the present time, or have had in the past, please check the symptoms that apply to you. Use x, xx, xxx, or xxxx to indicate the severity of the problem. Check only those symptoms that apply to you. Please note whether the problem is present, past, or both.

Past	Now	CARDIOLOGY
_____	_____	Rapid beating heart
_____	_____	Slow beating heart
_____	_____	High blood pressure
_____	_____	Low blood pressure
_____	_____	Pain over your heart
_____	_____	Ankles swell
_____	_____	Varicose veins
_____	_____	Shortness of breath
_____	_____	Hands and feet cold
_____	_____	Blood clots
_____	_____	Skipped heart beat
_____	_____	Heart murmur
_____	_____	Chest pain with left arm pain

		RESPIRATORY
_____	_____	Chronic cough
_____	_____	Spitting phlegm
_____	_____	Spitting blood
_____	_____	Difficult breathing
_____	_____	Wheezing
_____	_____	Chest pain
_____	_____	Allergies
_____	_____	Night sweats
_____	_____	Snoring
_____	_____	Sinus trouble
_____	_____	Nasal polyps
_____	_____	Fluid "rattling" in lungs
_____	_____	Tightness in chest

		URINARY
_____	_____	Frequent urination
_____	_____	Painful urination
_____	_____	Blood in urine
_____	_____	Pus in urine
_____	_____	Frequent kidney infection
_____	_____	Bed wetting
_____	_____	Inability to control urine
_____	_____	Urgent urination
_____	_____	Urine dribbles
_____	_____	Awaken at night to urinate
_____	_____	Kidney stones
_____	_____	Difficulty passing urine
_____	_____	Bladder infections

Past	Now	GASTROINTESTINAL
_____	_____	Poor appetite
_____	_____	Excessive hunger
_____	_____	Poor digestion
_____	_____	Belching or gas
_____	_____	Nausea
_____	_____	Vomiting
_____	_____	Difficult swallowing
_____	_____	Excessive thirst
_____	_____	Diarrhea
_____	_____	Acid foods upset
_____	_____	Eat when nervous
_____	_____	Hunger between meals
_____	_____	Feel shaky when hungry
_____	_____	Eating relieves fatigue
_____	_____	Faint feeling, when hungry
_____	_____	Heart palpitations, if meals missed/delayed
_____	_____	Afternoon headaches
_____	_____	Overeating sweets upsets
_____	_____	Feeling of incomplete bowel evacuation
_____	_____	Crave sweets or coffee
_____	_____	Crave other foods or beverages
_____	_____	Indigestion after meals
_____	_____	Greasy foods upset
_____	_____	Stools light colored
_____	_____	Gallbladder attack
_____	_____	Constipation
_____	_____	Use laxatives
_____	_____	Blood in stool
_____	_____	Black stools
_____	_____	Hemorrhoids (Piles)
_____	_____	Intestinal worms
_____	_____	Jaundice
_____	_____	Abdominal swelling
_____	_____	Abdominal pain or cramps
_____	_____	Change in bowel habits
_____	_____	Weight problem
_____	_____	Burning or itching anus
_____	_____	Headaches upon arising; wears off during day _____ yes _____ no
_____	_____	Bowel movements painful

Past	Now	SKIN
____	____	Dry Skin
____	____	Itching
____	____	Eruptions
____	____	Psoriasis
____	____	Bruise easily
____	____	Boils
____	____	Acne
____	____	Eczema
____	____	Sensitive skin
____	____	Gooseflesh common
____	____	Brown spots
____	____	Bronzing of skin
____	____	Excessive perspiration
____	____	Changing mole
____	____	Other skin problem (Describe)

_____

EARS

____ ____ Deafness R ____% L ____%
____ ____ Wear a hearing aid
____ ____ Discharge
____ ____ Ringing or noises in the ears
____ ____ Eardrum punctured
____ ____ Recurrent ear infection
____ ____ Mastoiditis
____ ____ Earache(s)

EYES

____ ____ Wear glasses
Age first prescribed ____
____ ____ Nearsighted
____ ____ Farsighted
____ ____ Astigmatism
____ ____ Blurred vision
____ ____ Loss of vision R ____ L ____
____ ____ Eyes burn
____ ____ Eyes feel gritty
____ ____ Glare bothers
____ ____ Nightblindness
____ ____ Bloodshot eyes
____ ____ Pain in eyes
____ ____ Cataracts
____ ____ Eyes bulge
____ ____ Eyelids puffy
____ ____ Crossed eyes (muscle weakness)
____ ____ Excessive itching

NOSE

____ ____ Sinusitis
____ ____ Septal injury or defect
____ ____ Postnasal drip
____ ____ Frequent colds
____ ____ Allergy
____ ____ Frequent sneezing
____ ____ Change in sense of smell
____ ____ Itches frequently
____ ____ Difficult breathing through nose (stuffed)
____ ____ History of Nasal Polyps

Past	Now	MOUTH-THROAT
____	____	Sore mouth (canker sores)
____	____	Sore gums
____	____	Bleeding gums
____	____	Bad breath
____	____	Sore throats (frequent)
____	____	Swollen glands
____	____	Wear dentures
		Age first used ____
____	____	Severe toothaches
____	____	Bitter taste in A.M.
____	____	Decreased salivation
____	____	Increased salivation

MUSCLES, JOINTS, NERVES

____ ____ Weakness
____ ____ Twitching
____ ____ Neck pain
____ ____ Pain between shoulder blades
____ ____ Low back pain
____ ____ Swollen joints
____ ____ Tremors
____ ____ Pain in tailbone
____ ____ Headaches
____ ____ Spinal curvature
____ ____ Faulty posture
____ ____ Muscle spasms
____ ____ Leg or foot cramps (charley-horses)
____ ____ Frequent sore muscles
____ ____ Neck stiffness
____ ____ Cracking noises in neck
____ ____ Stiff joints upon arising
____ ____ Neuralgia
____ ____ Shoulder/arm/hand pain
____ ____ Leg/knee/ankle/foot pain
____ ____ Numbness or tingling, burning, "sleeping" or prickling sensation:
Arms __R __L Hands __R __L
Legs __R __L
____ ____ Tics, spasms or muscle jerking—head, eyes, face, shoulders

FEET

____ ____ High instep
____ ____ Fallen arches
____ ____ Pain in arches
____ ____ Cramps in feet or toes
____ ____ Swollen ankles
____ ____ Excessive perspiration
____ ____ Use foot appliance
____ ____ Change of heels cause pain
____ ____ Bunions R ____ L ____
____ ____ Corns
____ ____ Callouses
____ ____ Plantar warts
____ ____ Heel spurs
____ ____ Wear shoes over: Inwardly __ R __ L
Outwardly __ R __ L
____ ____ Athlete's Foot
____ ____ Ingrown Toenails

Past Now NERVOUS SYSTEM
PSYCHOLOGICAL

_____ _____ Depression
_____ _____ Excessive worry
_____ _____ Cry easily
_____ _____ Outbursts of anger
_____ _____ Nightmares
_____ _____ Recurrent dreams
_____ _____ Forgetfulness
_____ _____ Excessive fear:
_____ _____ Height
_____ _____ Closed spaces
_____ _____ Darkness
_____ _____ Being alone
_____ _____ Other: _____
_____ _____ Awaken tired, exhausted
_____ _____ Nervousness
_____ _____ Hear sounds or voices
_____ _____ See visions
_____ _____ Food craving
_____ _____ Dizziness
_____ _____ Paralysis
_____ _____ Shakiness
_____ _____ Feel faintness
_____ _____ Confusion
_____ _____ Feel "keyed up"
_____ _____ Lack energy
_____ _____ Heart pounds
_____ _____ Heart races
_____ _____ Hot or cold spells
_____ _____ Bite nails
_____ _____ Convulsions or epilepsy
_____ _____ Stuttering or stammering
_____ _____ Walk in sleep
_____ _____ Severe headaches
_____ _____ Chronic fatigue
_____ _____ Other_____

ENDOCRINE

_____ _____ Thirsty all the time
_____ _____ Cold most of the time
_____ _____ Too warm most of the time
_____ _____ Unusually tired or sluggish
_____ _____ Unusually jumpy or nervous

MEN ONLY

_____ _____ Prostate trouble
_____ _____ Lumps in testicles
_____ _____ Diminished sexual activity
_____ _____ Painful urination
_____ _____ Swelling of testicles
_____ _____ Dribbling urination
_____ _____ Discharge from urethra
_____ _____ Swelling external genitalia
_____ _____ Painful external genitalia
_____ _____ Sores on external genitalia
_____ _____ Impotency

Past Now WOMEN ONLY

_____ _____ Painful menstrual periods
_____ _____ Irregular cycles
_____ _____ Excessive flow
_____ _____ Cramps
_____ _____ Backache during menstruation
_____ _____ Hot flashes
_____ _____ Vaginal discharge
_____ _____ Lumps in breast
_____ _____ Previous miscarriage(s)
_____ _____ Tubal pregnancy
_____ _____ Caesarean section delivery
_____ _____ Acne worse at menstruation
_____ _____ Hair growth on face or body
_____ _____ Depressed before menstrual periods
_____ _____ Ovarian cyst(s)
_____ _____ Painful intercourse
_____ _____ Other GYN problems (describe)
_____

General Information — WOMEN ONLY

_____ Age menstrual periods started
_____ Pregnant now ____ Months
_____ Age when menstrual period stopped
_____ Still menstruating regularly
_____ Take birth control pills
____ Now ____ Previously
_____ Number of successful pregnancies

Thank you for answering the following questions. A complete understanding of your health status will facilitate proper evaluation. Have you ever had a spinal tap or spinal injection? ____ Yes ____ No Year _____
For what reason? _____
List the medications you are presently taking:
_____
How long have you been taking these medications?
_____
I was last given medical treatment for _____
_____ by Dr. _____. I was last hospitalized for _____
Where _____ When _____
When did you last have a complete physical examination? _____ Results? _____
Who is your family physician? _____
Who is your family dentist? _____
Who is your family chiropractor? _____
Who is your family eye doctor? _____
Have you ever had to consult a podiatrist (foot specialist)? __ Yes __ No If so, whom and when and for what condition? Dr.'s name _____
Year _____ Condition _____
To what extent do you use the following dairy products: milk ____ (glasses per day), cheese, ice cream, butter, cottage cheese, yogurt, buttermilk)?
Heavy __ Average __ Little __

In what quantity do you use the following per day? Coffee ___ (cups) Tea ___ Chocolate ___ Cola (Coke, Pepsi, RC, Tab, Dr. Pepper, Diet, Mello-Yello, Mountain Dew) ___(oz. per day) Excedrin ___ Empirin ___ Aspirin ___ Tylenol ___ Datril ___ Cope ___ Midol ___ Vanquish ___ Antihistamines (Dristan, Allerest, etc.) (Tablets per day)
Other non-prescription drugs _____ Cigarettes ____(pks.) Chewing tobacco ____ Alcohol ____ (oz. per wk.)
Give the extent to which you use the following: Refined carbohydrates (foods made with white sugar and white flour) ____ Heavy ____ Average ____ Light. Sodium Chloride (table salt or salty foods) ____ Heavy ____ Average ____ Light. Fresh fruits and vegetables and juices ____ Heavy ____ Average ____ Light. Proteins: (meat, eggs, fish, cheese, nuts, beans) ____ Heavy ____ Average ____ Light. Do you use laxatives? ____ How often? _____.
Are you on a special diet? ____ If yes, describe _____.
List vitamin and mineral supplements you are using_____.
How many glasses of water do you drink each day? ____ Are you right handed ____ left handed ____ ambidextrous (both) ____ Is your present mattress: firm ___ moderate ___ soft ___ how old? ____ yrs. Conventional? ___ Waterbed? ____ Do you use a pillow? ____ more than one? ____ soft ___ medium ___ firm ___ feather ___ foam ___ thick ___ thin ___ Sleeping posture: Back ___ Side ___ Stomach ___ Stomach/side combination ___ Shoe size? ___ Width ___ Earth shoe? ___ Elevated heel? ___ Do you have difficulty obtaining properly fitted shoes? ___ Yes ___ No.
MEN: Do you carry your billfold in a back pocket? ___ Yes ___ No
How many miles do you travel each day to and from work? ____ miles.

RECREATIONAL ACTIVITIES

Which of the following activities do you participate in and with what regularity?

	Freq.	Occas.	Rare
____ Bowling	____	____	____
____ Tennis	____	____	____
____ Racquetball	____	____	____
____ Swimming	____	____	____
____ Water skiing	____	____	____
____ Downhill skiing	____	____	____
____ Cross-country skiing	____	____	____
____ Baseball	____	____	____
____ Softball	____	____	____
____ Golf	____	____	____
____ Rope skipping	____	____	____
____ Walking (hiking)	____	____	____
____ Running	____	____	____
____ Rebounding (tramp.)	____	____	____
____ Snowmobiling	____	____	____
____ Snow shoeing	____	____	____
____ Hockey	____	____	____
____ Ice skating	____	____	____
____ Boxing	____	____	____
____ Wrestling	____	____	____
____ Weight-lifting	____	____	____
____ Bicycling	____	____	____
____ Horseback riding	____	____	____
____ Motorcycling	____	____	____
____ Auto racing	____	____	____
____ Sky diving	____	____	____
____ Handball	____	____	____
____ Soccer	____	____	____
____ Football	____	____	____
____ Basketball	____	____	____
____ Horseshoes	____	____	____
____ Back-packing	____	____	____
____ Fishing	____	____	____
____ Hunting	____	____	____
____ Canoeing	____	____	____
____ Dancing	____	____	____
____ Rollerskating	____	____	____

____ Other (describe)_____

HOBBIES AND INTERESTS

Which of the following activities do you enjoy?

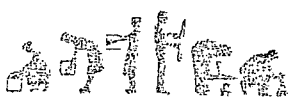
	Freq.	Occas.	Rare
____ Reading	____	____	____
____ Writing	____	____	____
____ Cooking	____	____	____
____ Sewing	____	____	____
____ Crocheting	____	____	____
____ Knitting	____	____	____
____ Needlepoint	____	____	____
____ Carving	____	____	____
____ Painting	____	____	____
____ Drawing/Sketching	____	____	____
____ Flying (private)	____	____	____
____ Public Speaking	____	____	____
____ Volunteer Work	____	____	____
____ Church Activities	____	____	____
____ Political Activity	____	____	____
____ Traveling	____	____	____
____ Photography	____	____	____
____ Camping	____	____	____
____ Boating	____	____	____

____ Other (describe)_____

Please indicate the number of X-rays you have had in the past five years of each of the following body parts:

____ Lungs
____ Skull
____ Lower spine and pelvis
____ Upper spine and neck
____ Teeth and/or jaw
____ Upper G.I.
____ Lower G.I.
____ Kidneys
____ C.A.T. Scan
____ Wrist-Hand
____ Elbow-Arm
____ Shoulder
____ Knee
____ Leg
____ Ankle-Foot
Other (describe) _____

Thank you very much!



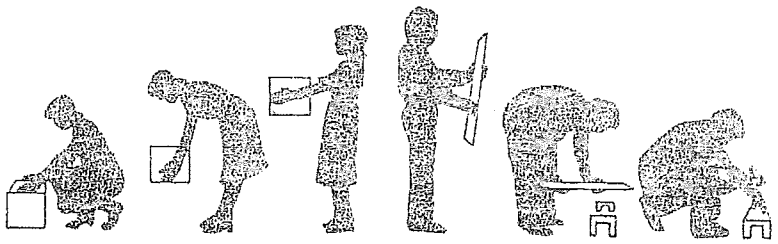
FORM # 0002-1

employee to fill out

IACOHC

International Academy of Chiropractic
Occupational Health Consultants

HISTORY OF NEUROMUSCULOSKELETAL INJURIES, DISORDERS AND CONDITIONS



HISTORY OF NEUROMUSCULOSKELETAL INJURIES, DISORDERS AND CONDITIONS

EXAMINEE NAME _____ DOCTOR _____ DATE ____/____/____
(LAST) (FIRST) (MIDDLE)

EXAMINEE AGE _____ SEX: M F CODE _____/_____/_____/_____/_____

1. Have you ever injured the arches of either of your feet? (Sprains, Strains, Crushing Injuries, Fractures, etc.)
____ Yes ____ No If yes: ____ Right ____ Left ____ Both ____ Mild ____ Moderate ____ Severe
Description of the injury: _____ Year ____
How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor

2. Have you ever required surgery on either of your feet? ____ Yes ____ No
If Yes: ____ Right ____ Left ____ Both Purpose of the surgery? _____

3. Do your feet ever bother you now? ____ Yes ____ No

4. Do you ever get "charley-horses" or cramps in any of the following muscles?
____ Arches of the feet ____ Calf muscles ____ Shin muscles ____ Hamstring muscles ____ Lower spinal muscles ____ Upper spinal or neck muscles.

5. Have you ever had or do you presently have "heel spurs"? ____ Yes ____ No
If Yes: ____ Right ____ Left ____ Both

6. Do either of your heels bother you now? ____ Yes ____ No

7. Do you have to wear special arch supports or removable appliances in your shoes because of difficulties with your feet? ____ Yes ____ No

8. Does it bother you to be on cement or other hard surface floors for prolonged periods of time? ____ Yes ____ No

9. Is it difficult for you to "break-in" new shoes? ____ Yes ____ No

10. Do your feet become unusually cold? ____ Yes ____ No

11. Do you have excessive perspiration of your feet? ____ Yes ____ No

12. Do you suffer from ingrown toenails? ____ Yes ____ No

13. Do you presently have or have you had plantar's warts on your feet? ____ Yes ____ No

14. As a baby or small child, did you have any deformities of your feet, such as "club" feet? ____ Yes ____ No

15. Do you ever suffer severe athlete's foot or other fungus infections of your feet? ____ Yes ____ No

16. Have you ever suffered a significant injury to either of your ankle joints (Sprains, Strains, Blows, Crushing injuries, Fractures, etc.) ____ Yes ____ No
If Yes: ____ Right ____ Left ____ Both ____ Mild ____ Moderate ____ Severe
Description of the injury _____ Year ____
How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor

17. Would you judge either of your ankles to be "weak" now as the result of an old injury? ____ Yes ____ No
If Yes: ____ Right ____ Left ____ Both

18. Have you ever required surgery on either of your ankle joints? ____ Yes ____ No
If Yes: ____ Right ____ Left ____ Both ____ Year Describe what was done: _____
Results: ____ Excellent ____ Good ____ Fair ____ Poor

19. Do either of your ankle joints swell after being on them for prolonged periods? ____ Yes ____ No
If Yes: ____ Right ____ Left ____ Both

20. Do either of your ankle joints bother you in any way, such as pain, stiffness, loss of range of motion, swelling, etc.? ____ Yes ____ No

21. Did you ever injure or cut your Achilles' tendon of either leg: ____ Yes ____ No
If Yes: ____ Right ____ Left ____ Both ____ Year Did you have to have surgery to correct the Achilles' tendon injury? ____ Yes ____ No Results: ____ Excellent ____ Good ____ Fair ____ Poor

22. Have you ever suffered a severe injury (such as a strain, deep bruise, contusion, deep cuts, puncture wounds) to either of your calf muscles: ____ Yes ____ No
If Yes: ____ Right ____ Year ____ Left ____ Year ____ Both ____ Year
Did the injuries require treatment from a doctor? ____ Yes ____ No
Describe treatment given:_____
How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor

23. Have you ever fractured either of the bones in your lower leg? ____ Yes ____ No
If Yes: ____ Right ____ Year ____ Left ____ Year ____ Both ____ Year
____ Large bone (tibia) ____ Small bone (fibula) Was the fracture simple or compound? _____
Did you have to have involved treatment for the fracture, such as hospitalization, traction, use of surgical reduction with use of pins, screws, plates, etc.? ____ Yes ____ No How long did you have to be in a cast? ____ weeks How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor Is there any pain, swelling, muscle wasting, loss of function or other impairment as the result of that fracture? ____ Yes ____ No

24. Have you ever injured either of your knee joints (such as bad sprains, torn cartilages, crushing blows, etc.)? ____ Yes ____ No If Yes: ____ Right ____ Year ____ Left ____ Year ____ Both ____ Year Describe the injury(ies) _____
Did any of your knee joint injuries ever require surgery?
____ Yes ____ No If yes: ____ Right ____ Year ____ Left ____ Year ____ Both ____ Year
What was accomplished in the surgery? Removal of cartilage ____ Repair of ligaments ____ Removal of bone chips ____ Removal of spurs ____ Plastic replacement of the entire joint ____ Do you have any pain, swelling, stiffness, loss of range of motion or muscle wasting as the result of the knee inury? ____ Describe
_____
How would you describe your recovery from your knee injury? ____ Excellent ____ Good ____ Fair ____ Poor
Are you able to squat comfortably on both knees? ____ If not, describe _____
_____
Do you ever develop "water on the knee"? ____ Yes ____ No If Yes: ____ Right ____ Left ____ Both
Do you ever have to have fluid removed from your knee joints?
____ Yes ____ No If Yes: ____ Right ____ Left ____ Both
Do your knee joints snap, grate, pop or click when you squat or bend them? ____ Yes ____ No
Have you ever had bursitis in either of your knee joints?
____ Yes ____ No If Yes: ____ Right ____ Left ____ Both

25. Have you ever crushed or fractured either of your kneecaps? ____ Yes ____ No
If yes: ____ Right ____ Year ____ Left ____ Year ____ Both ____ Year
What was the method of treatment? ____ Ace bandage and use of crutches ____ Plaster cast and use of crutches ____ Surgical wiring followed by plaster cast and crutches ____ Surgical removal of the entire kneecap. Did you have a good recovery from the fractured kneecap? ____ Yes ____ No If not, describe ____
_____

26. Have you ever suffered a dislocated patella (Kneecap)?
____ Yes ____ No If yes: ____ Right ____ Year ____ Left ____ Year ____ Both ____ Year
If so, was it treated by a doctor? ____ Yes ____ No Has it ever recurred? ____ Yes ____ No

27. Has any doctor ever said that you have "arthritis" in your knees? ____ Yes ____ No If yes, describe when and what treatment was given or recommended _____
_____

28. Have you ever suffered any injury(ies) to either of your thigh muscles ____ Yes ____ No ____ Year If yes, describe the exact location of the injury _____
Describe the injury (deep bruise from a direct blow, deep cut, strained or pulled muscle, etc.) _____
_____
How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor

29. Have you ever fractured the large femur bone in either of your upper legs? ____ Yes ____ No
If yes: ____ Right ____ Year ____ Left ____ Year ____ Both ____ Year Was it a (circle one) simple, non-displaced fracture, or a compound (displaced or multiple fragments) fracture? What was the method of treatment for the fracture(s)? ____ Long plaster cast and crutches, doctor's office or clinic only. ____ Hospitalization, traction, closed reduction and plaster cast and crutches. ____ Hospitalization, traction, surgical open-reduction with use of metal screws, pins, plates or wiring, followed by plaster casting and crutches. Describe your recovery from the fracture: ____ Excellent ____ Good ____ Fair ____ Poor

30. Have you ever injured either of your hip (ball and socket) joints?
____ Yes ____ No If yes: ____ Right ____ Year ____ Left ____ Year ____ Both ____ Year
Describe the injury or condition: ____ Fracture ____ Dislocation ____ Sprain ____ Bursitis What was the method of treatment _____
How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor

31. Have you ever strained either of your groin muscles? ____ Yes ____ No
If yes: ____ Right ____ Year ____ Left ____ Year ____ Both ____ Year Describe the injury _____
_____
Describe the recovery ____ Excellent ____ Good ____ Fair ____ Poor

32. Did you ever injure your tailbone? ____ Yes ____ No ____ Year If yes: Describe the injury _____
_____ Describe the treatment _____
Describe the recovery ____ Excellent ____ Good ____ Fair ____ Poor

33. Have you ever fractured your pelvis? ____ Yes ____ No If yes, describe when, where, how, etc. _____
_____
Describe the method of treatment_____
_____
Describe your recovery ____ Excellent ____ Good ____ Fair ____ Poor

34. Have you ever injured your lower spine? ____ Yes ____ No If yes, describe the injury(ies) _____
_____
Describe method of treatment for your spine_____
Do you have backaches now? ____ Yes ____ No If yes, describe the location, type of pain, when it bothers the most _____
_____

35. Have you ever injured your ribs (fractures, separations, dislocations, etc.) ____ Yes ____ No ____ Year
If yes, describe _____

36. Have you ever injured your upper spine or neck? ____ Yes ____ No If yes, describe (what happened, when, where, how, etc.) _____

_____

Describe your recovery ____ Excellent ____ Good ____ Fair ____ Poor

37. Have you ever injured either of your collar bones? ____ Yes ____ No If yes, describe (what happened, when, where, how) _____
Describe your recovery ____ Excellent ____ Good ____ Fair ____ Poor

38. Have you ever injured either of your shoulder joints? ____ Yes ____ No If yes, describe (what happened, when, where, how) _____
Describe your recovery ____ Excellent ____ Good ____ Fair ____ Poor Does (do) your shoulder(s) still bother you now? ____ Yes ____ No If yes, describe your shoulder impairment or how they (it) bother(s) you

_____

39. Have you ever fractured either of your upper arm (humerus) bones? ____ Yes ____ No If yes, describe (what happened, when, where, how) _____

_____

40. Have you ever injured either of your elbow joints? (fractures, dislocation, chipped bones, bursitis, tendonitis, severe contusions, sprains, strains, etc.) ____ Yes ____ No How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor If any, describe your impairment or loss of function (pain, stiffness, loss of motion, inability to extend, flex or rotate, swelling, etc.) _____

_____

How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor

41. Have you ever fractured, dislocated or severely sprained either of your wrist joints? ____ Yes ____ No
If yes, describe (what happened, when, where, how) _____

_____

Describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor If any, describe your impairment or loss of function (stiffness, pain, swelling, impaired range of motion, weakness, etc.) _____

_____

42. Have you ever fractured or dislocated any of the bones or joints in your hands or fingers? ____ Yes ____ No
If yes, describe (what happened, when, where, how) _____

_____

Describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor If any, describe impairment or loss of function (such as stiffness, pain, loss of motion, numbness, swelling) _____

43. Have you ever had surgery on any of the tissues of your hands or wrists? ____ Yes ____ No If yes, describe what was done _____ Year ____

44. Have you ever suffered a skull fracture? ____ Yes ____ No If yes, describe (what happened when, where, how) _____
Describe your recovery ____ Excellent ____ Good ____ Fair ____ Poor If any, describe your impairment (such as loss of vision, hearing, memory, disturbed equilibrium, inability to concentrate, etc.) _____

_____

45. Have you ever been knocked unconscious? ____ Yes ____ No If yes, describe (what happened, when where, how, etc.) _____

_____

46. Have you ever had a brain concussion? ____ Yes ____ No If yes, describe (what happened, when, where, how, etc.) _____
Did you have to be hospitalized? ____ Yes ____ No If yes, for how long? ____ How would you describe your recovery from the brain concussion? ____ Excellent ____ Good ____ Fair ____ Poor If any, describe any impairments or loss of function you have had as the result of the brain concussion (such as dizziness, inability to concentrate, loss of vision, hearing, loss of balance, etc.)_____

47. Have you ever suffered a gunshot or stab wound? ____ Yes ____ No If yes, describe (what happened, when, where, how, etc.) _____

48. Have you ever suffered any severe burns on your body? ____ Yes ____ No If yes, describe (what happened, when, where, how, etc.) _____
_____
How would you describe your recovery ____ Excellent ____ Good ____ Fair ____ Poor If any, describe any impairments or loss of function from the burn injury _____

49. Have you ever been hurt on the job and filed for workers' compensation benefits? ____ Yes ____ No If yes, describe (what happened, when, where, how) _____
_____
Who was your employer at the time of the injury(ies)_____
Who was your doctor(s) for the care required for the work related injury? _____
How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor Was there a percentage of permanent partial disability granted to you as the result of the work-related injury? ____ Yes ____ No
If yes, what was the percentage of impairment rating and to what parts of the body? ____% to: _____
_____

50. Have you ever fractured your jaw? ____ Yes ____ No If yes, describe (what happened, when, where, how, etc.)
_____
How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor

51. Have you ever broken your nose? ____ Yes ____ No If yes, describe (what happened, when, where, how, etc.)
_____
How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor

52. Have you ever chipped, broken or lost any of your teeth as the result of injury to your face or head? ____ Yes ____ No If yes, describe (what happened, when, where, how, etc.) _____
_____
How would you describe your recovery? ____ Excellent ____ Good ____ Fair ____ Poor

53. Have you ever had to use cortisone or related drugs such as "prednisone" therapy for any reason? ____ Yes ____ No If yes, when, for how long and for what condition(s)? _____
_____ Was the cortisone injected or prescribed in tablet form? _____

54. Have you ever had cobalt or other radiation therapy for any form of cancer in your body? ____ Yes ____ No If yes, when and for what conditions(s)? _____
_____

55. Have any of the following family members ever suffered disabling lower spinal difficulties (such as hospitalization, traction, surgery, body casts, etc.)
Father ____ If yes, describe _____
Mother ____ If yes, describe _____
Brother(s) ____ If yes, describe _____
Sister(s) ____ If yes, describe _____

56. Have you ever been involved in a vehicular accident involving any of the following:
____ Automobile ____ Snowmobile ____ Airplane ____ Boat ____ Tractor ____ Truck or Van ____ Motorcycle
____ Train ____ Other: _____ Year _____
Did you suffer any injury(ies) which required the attention of a doctor as the result of any of the above accidents? ____ Yes ____ No If yes, describe what parts of your body were injured and what type of treatment you received _____
_____
Describe your recovery ____ Excellent ____ Good ____ Fair ____ Poor

57. Have you ever suffered any of the following:
____ Ruptured spleen ____ Ruptured urinary bladder ____ Detached retina (eye) ____ Collapsed lung
____ Diaphragmatic hernia ____ Severely bruised or injured kidney(s)
If yes, describe what happened, when, where, how, etc. _____
_____

58. Please discuss any other injury(ies), malformation(s) or disease of your body not previously mentioned or described in this questionnaire _____
_____
_____
_____
_____
_____
_____
_____

Thank you very much!