ChiropractieArnhem

Confidential questionnaire

Name: _____
First Name: _____
Initals: _____ **Male / Female**
Maiden name: _____
Address: _____
Zipcode: _____
City: _____
Date of Birth: _____
Married: yes - no **No. of Children:** _____

Telephone: _____
Cellular phone: _____
Work phone: _____
BurgerServiceNr.: _____

Name physician: _____
Address physician: _____
Telephone physician: _____
Insurance comp.: _____
Policy nr.: _____

Occupation: _____
Employed? yes - no

Who referred you to us:
◊ general practitioner: _____ ◊ family: _____
◊ internet: _____ ◊ advertisement: _____
◊ friend: _____ ◊ other: _____

What is your main complaint:

_____
_____
_____
_____
_____

When did you notice your complaint for the *first time?*

_____

What is the cause of your complaint? _____

_____

Is this complaint start *suddenly* or *gradually*?
Do you feel the pain *constantly* or *intermittenlty*?

Do you feel radiating pain to your:
◊ Arm left - right ◊ Leg left - right

More painful when:
◊ sitting
◊ walking
◊ standing
◊ bending
◊ laying
◊ moving
◊ turning the head
◊ coughing / sneezing / sque
◊ morning
◊ afternoon
◊ evening

Less pain when:
◊ sitting
◊ walking/moving
◊ standing
◊ bending
◊ laying

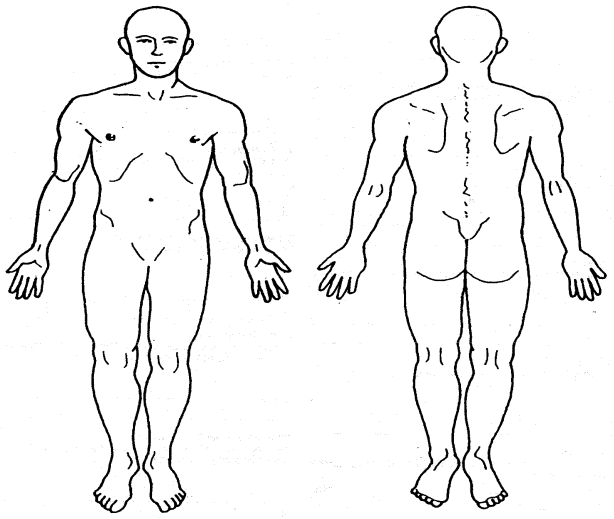
Have you ever consulted anyone else for this problem?
◊ chiropractor
◊ physician
◊ fysiotherapist
◊ manual therapist
◊ ceasar therapist
◊ neurologist
◊ orthopedist
◊ reumatologist
◊ psychiatrist
◊ homeopath
◊ acupuncturist
◊ osteopath
◊ podietrist
◊ others nl:

Have you ever consulted a chiropractor? yes - no

Have you had any of the following exams
If yes, which and when was the last time?
◊ X-rays _____
◊ MRI _____
◊ heart exam _____
◊ blood/urine test _____

When and why was your last appointment with your:
◊ physician _____
◊ dentist _____

Please indicatie where you feel your problem:



What number (between 1-10) would you give your pain?

0 (no pain) (heavy pain) 10

Nutrition
Do you have a good appetite yes - no
Do you drink > 5 glasses of water per day? yes - no
Do you drink > 5 cups of coffeer per day? yes - no
Do you drink > 2 glasses of alcohol per day? yes - no
Do you smoke? If yes, how much? yes - no

Do you work out? yes - no
How many times per week? _____
Which sports? _____
Do you walk more than 30 minutes per day? yes - no

Do you sleep through the night? yes - no
How do you sleep? back - stomach - side

Do you use medication? yes - no
If yes, which? _____

Do you use vitamins? yes - no
If yes, which? (Brand and type) _____

Remember to fill in the back!

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PROBLEMS WITH MUSCLES AND JOINTS

previous	current		
◊	◊	neck	
◊	◊	upper back	
◊	◊	shoulder blades	
◊	◊	lower back	
◊	◊	tailbone	
◊	◊	groin	Left - Right
◊	◊	hip	Left - Right
◊	◊	leg	Left - Right
◊	◊	knee	Left - Right
◊	◊	foot/ankle	Left - Right
◊	◊	shoulder	Left - Right
◊	◊	arm	Left - Right
◊	◊	elbow	Left - Right
◊	◊	hand	Left - Right
◊	◊	wrist	Left - Right
◊	◊	fingers	Left - Right

PROBLEMS OF COMMON NATURE

previous	current	
◊	◊	headache
◊	◊	migraine
◊	◊	dizziness
◊	◊	tinnitus L - R
◊	◊	facial pain
◊	◊	sleeplessness
◊	◊	fatigue
◊	◊	nervousness
◊	◊	depression
◊	◊	fainting
◊	◊	allergies
◊	◊	otitis L - R
◊	◊	deafness L - R
◊	◊	laryngitis
◊	◊	eye symptoms
◊	◊	sinusitis

DESEASES YOU HAVE HAD

◊ rheumatism
◊ osteoarthritis
◊ arthritis
◊ osteoporosis
◊ gout
◊ whiplash
◊ RSI
◊ pfeiffer
◊ diabetes
◊ aids
◊ tbc
◊ MS
◊ fibromyalgia
◊ myocardial infarction
◊ stroke
◊ epilepsy
◊ thyroid
◊ cancer
◊ other: _____

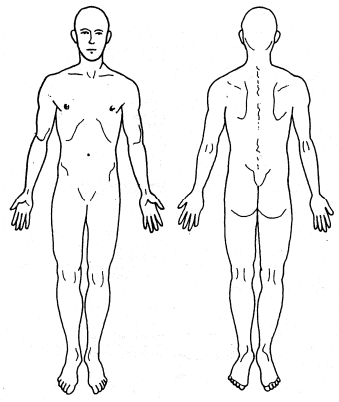
PROBLEMS WITH MENSTRUATION AND PREGNANCY

yes	no	
◊	◊	menstruationpain
◊	◊	irregular menstruation
◊	◊	back pain during menstruation
◊	◊	had problems with menopause
◊	◊	had miscarriage
◊	◊	are you pregnant?

ACCIDENTS, INJURIES AND OPERATIONS:

yes	no	Have you:
◊	◊	Had a car accident? If yes, when? How were you hit: ◊ from behind ◊ front ◊ from the side Were you the *driver* or *passenger*?
◊	◊	Have you injured you neck or back in any other way? If yes, where and how? _____
◊	◊	Have you had broken bones? If yes, which? _____
◊	◊	Have you had operations? If yes, which? _____

Can you mark all your **scars** below?



DENTAL

yes	no	Do you have:
◊	◊	Dentures? *upper - lower*
◊	◊	Crowns?
◊	◊	Amalgam fillings?
◊	◊	A bridge?
◊	◊	A plate?
◊	◊	Had braces?

GENERAL

◊ orthotics
◊ heel lift: L - R
◊ piercings
◊ Other: _____

DID/DO THE FOLLOWING COMPLAINTS APPLY TO YOU?

◊ heart and blood vessels: _____
◊ lungs and respiratory: _____
◊ stomach, bowels and/or stool: _____
◊ skin: _____

Comments: _____

yes	no	
◊	◊	May we inform your physician?
◊	◊	May the chiropractor call you on your home phone?
◊	◊	May we use your e-mail? (only for the practice, your e-mail will never be shared with a third party) If yes, your e-mail is: _____

With your signature you give permission for the chiropractic examination

SIGNATURE

Date: _____