

**CHIROPRACTIE RUGKLINIEK HEERLEN**  
**CONFIDENTIAL QUESTIONNAIRE ADULTS ( 12 years and older)**

**Please fill in with red**

**Gentlemen**

Surname: .....  
 Initials: ..... M/F  
 First name: .....  
 Date of birth: .....  
 Address: .....  
 Zip: .....  
 City: .....  
 Home phone: .....  
 Work phone: .....  
 Mobile phone: .....  
 E-mail-address: .....

Number of children: .....  
 Occupation: .....  
 Are you working at the present time? Yes/No  
 Pastime/sports: .....  
 M.D. name: .....  
 M.D. address: .....

**May we contact or inform your M.D.? YES / NO**  
 ( Circle as appropriate)

Referred by: .....

**What is your major complaint?**  
 .....  
 .....  
 .....

**How long have you had this condition?**  
 .....  
 .....

**What is the cause of your complaint?**  
 .....  
 .....

**How did your complaint begin?**  
 Gradually  
 Suddenly

**Is your complaint:**  
 Intermittently present  
 Constantly present

**Is there a radiation to:**  
 Arm L/R  
 Leg L/R

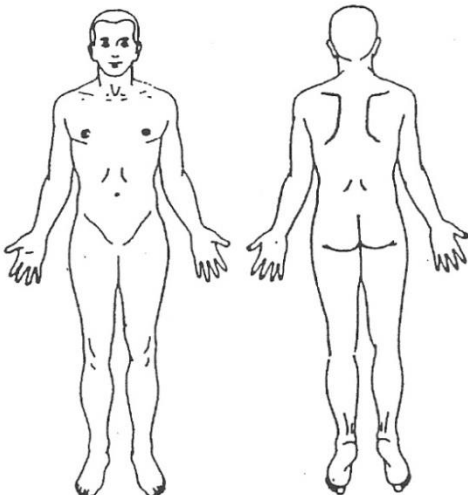
**Aggravating:**  
 Sitting  
 Walking  
 Standing  
 Bending  
 Lying down  
 Turning your head  
 Moving  
 Coughing/sneezing/straining  
 Other activities/postures:  
 .....

**Alleviating:**  
 Sitting  
 Walking  
 Standing  
 Bending  
 Lying down  
 Moving  
 Other activities/postures:  
 .....

**From 1 (light) to 10 (intense),  
 how to estimate your pain?.....**

**Medical professionals:**  
*Did you see one of these  
 professionals for your complaints:*  
 Chiropractor  
 Family doctor  
 Physiotherapist  
 Cesar/Mensendieck  
 Manual therapist  
 Osteopath  
 Podotherapist  
 Neurologist  
 Rehabilitation doctor  
 Rheumatologist  
 Acupuncturist  
 Surgeon  
 Pain clinic  
 Homeopathic doctor  
 Orthopedist  
 Psychologist  
 Alternative doctors  
 Other professionals:  
 .....  
 .....

**Please specify where your complaint is:**



**Muscle and joint problems**

**Past/Present**  
 Neck  
 Between shoulders  
 Lower back  
 Tailbone  
 Groin L/R  
 Hip L/R  
 Leg L/R  
 Knee L/R  
 Foot or heel L/R  
 Jaw  
 Shoulder L/R  
 Arm L/R

**Past/Present**  
 Elbow L/R  
 Hand L/R  
 Wrist L/R  
 Finger L/R  
 Ribs L/R  
 Bursitis  
 Swollen joints  
 Arthritis  
 Gout  
 Muscle weakness  
 Numbness

**General:**

**Past/Present**

- Headache
- Migraine
- Dizziness:
  - I spin
  - The room spins
- Fainting
- Fits of rage
- Difficulty sleeping
- Concentration problems
- Memory loss
- Phobias
- Tiredness
- Nervousness
- Allergies
- Depression
- Facial pain L/R
- Loss of appetite
- Sinusitis
- Convulsions
- Tremor:
  - Upon rest
  - Upon moving

**Gastro-Intestinal**

**Past/Present**

- Stomach pain
- Gastric acid
- Peptic ulcer
- Hiatus hernia
- Digestion problems
- Excessive hunger/thirst
- Gal bladder problems
- Liver problems
- Yellow skin
- Constipation/irregular bowel movements
- Diarrhea
- Vomiting/Nausea
- Hemorrhoids
- Flatulence
- Abdominal pain
- Appendicitis
- Other: .....

**Genito-Urinary**

**Past/Present**

- Bladder problems
- Nephritis
- Prostate problems
- Incontinence/inability to control bladder
- Urination problems
- Blood in urine
- Other: .....

**Do you use:**

**Past/present**

- Arch support or thotics
- Heel bars/lift L/R
- Other: .....

**Respiratory:**

**Past/Present**

- Hyperventilating
- Excessive sweating
- Asthma
- Bronchitis
- Pneumonia
- Emphysema
- Hay fever
- Chest pain
- Coughing up blood
- Coughing up slime:
- Chronic cough
- Shortness of breath
- Wheezing
- Other: .....

**Illnesses**

**Past/Present**

- Angina Pectoris
- Alcoholism
- Rheumatism
- Tuberculosis
- Diabetes
- Mononucleosis
- Epilepsy
- Cancer
- Multiple sclerosis
- Meningitis
- Thyroid disease
- Polio
- Other: .....

**Skin**

**Past/Present**

- Dry skin
- Itching
- Eczema
- Bruise easily/Skin eruptions
- Other: .....

**Do you sleep on your:**

- Back
- Side
- Stomach
- Variable

**How old is your mattress?**

.....

**Is your mattress comfortable?**

- Yes  No

**Cardio vascular**

**Past/Present**

- Heart disease
- Stroke
- High blood pressure
- Low blood pressure
- Varicose veins L/R
- Abnormal heart rate:
  - Irregular
  - too quick
  - too slow
- Bruising
- Anemia
- Cold feet
- Cold hands
- Swollen ankles
- Swollen hands
- Arteriosclerosis

**Eyes**

**Past/Present**

- Pain
- Altered vision:
  - Misty
  - Blots
- Double vision
- Light sensitive
- Other:.....

**Ears:**

**Past/Present**

- Pain
- Whistle
- Loss of hearing
- Tinnitus/sound
- Noise
- Other: .....

**Nose/Sinuses**

**Past/Present**

- Pain
- Slime
- Bleeding
- Loss of scent
- Chronic congestion
- Other: .....

**Mouth and throat**

**Past/Present**

- Pain
- Swollen glands
- False teeth
- Hoarseness
- Pain/difficulties swallowing
- Change of taste
- Teeth grinding during day or night
- Jaw fatigue in the morning
- Other:.....

