

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)

What is/are your complaint(s)?

.....

How long have you had this/these condition(s)?

.....

What is the cause of your complaint(s)?

.....

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:

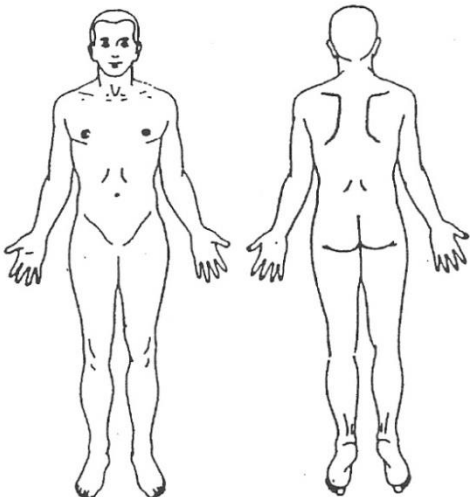
**From 1 (light) to 10 (intense),
 how to estimate your pain?.....**

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:.....

Please fill out as completely as possible even if it seems not related with your complaint(s).

Weight stable/loss/gain* * Circle as appropriate

Bone fractures (when, which).....

Hospitalizations (when, for what).....

Accidents (when, what).....

Surgical operations (when, which).....

Emotional disorders (which).....

Medications and for:

Nutrient vitamins and minerals? Which?

Are you experiencing any stress that may influence your complaints?

What diseases run in your family?

Date of last tests	Less than 6 months	Between 6-18 months	More than 18 months	Never
Urine test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MRI / CT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic examination:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac examination:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Habits:	Heavy	Normal	Moderate	None
Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Remarks?
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.....
.....
.....

Have you been vaccinated in the past 10 days? Yes / No

Signature:

Date: