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)?
…….
……..
……..

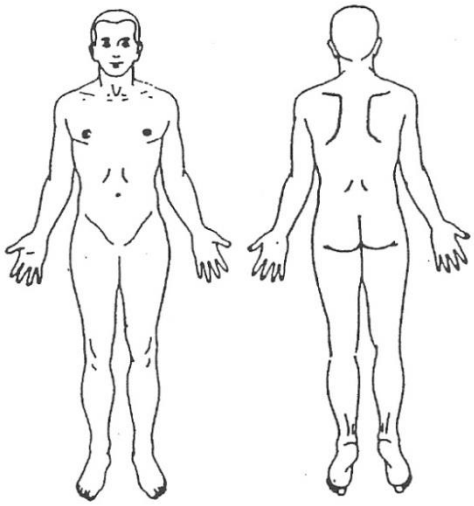
How did your complaint begin?
☐ Gradually
☐ Suddenly
Is your complaint:
☐ Intermittently present
☐ Constantly present
Is there a radiation to:
☐ Arm L/R
☐ Leg L/R

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

	Present	Past		Present	Past
Neck	☐	☐	Elbow L/R	☐	☐
Between shoulders	☐	☐	Hand L/R	☐	☐
Lower back	☐	☐	Wrist L/R	☐	☐
Tailbone	☐	☐	Finger L/R	☐	☐
Groin L/R	☐	☐	Ribs L/R	☐	☐
Hip L/R	☐	☐	Bursitis	☐	☐
Leg L/R	☐	☐	Swollen joints	☐	☐
Knee L/R	☐	☐	Arthritis	☐	☐
Foot or heel L/R	☐	☐	Gout	☐	☐
Jaw	☐	☐	Muscle		
Shoulder L/R	☐	☐	weakness	☐	☐
Arm L/R	☐	☐	Numbness	☐	☐

General:

	Present	Past
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:

	Present	Past
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

	Present	Past
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:	□	□	□	□
X-ray	□	□	□	□
MRI / CT	□	□	□	□
Blood test:	□	□	□	□
Chiropractic examination:	□	□	□	□
Cardiac examination:	□	□	□	□

Habits:	**Heavy**	**Normal**	**Moderate**	**None**
Appetite:	□	□	□	□
Coffee:	□	□	□	□
Alcohol:	□	□	□	□
Exercise:	□	□	□	□
Sleep:	□	□	□	□
Tobacco:	□	□	□	□
Drugs:	□	□	□	□

Remarks?

.....
.....
.....
.....

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

Sinature: **Date:**

..... **.....**