

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

**Please fill in with red**

**Ladies**

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 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:  
 .....

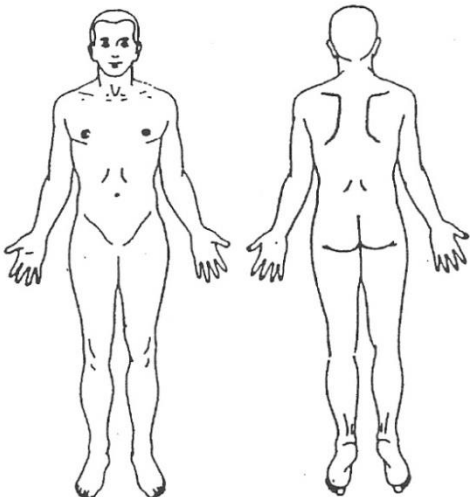
**From 1 (light) to 10 (intense),  
 how to estimate your pain?.....**

**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
- 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: .....

**For women only****Past/Present**

- Menstrual cramps
- Menstrual backache
- Irregular cycle
- Excessive menstrual bleeding
- Are you pregnant? .....
- Menopause problems
- 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?**  
 .....  
 .....  
 .....

**Sinature:** .....

**Date:** .....