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?
…..…….
……..
……..

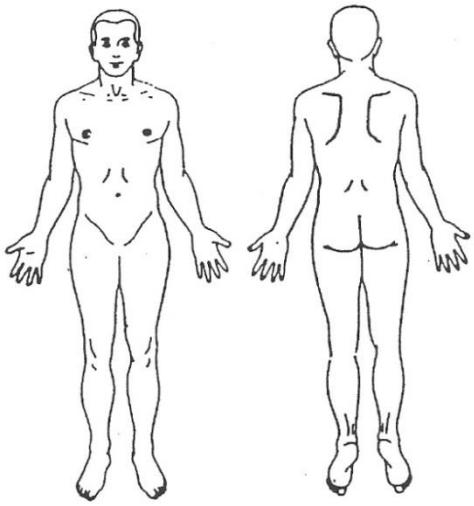
How did your complaint begin?
☐ Gradually
☐ Suddenly
Is your complaint:
☐ Intermittently present
☐ Constantly present
Is there a radiation to:
☐ Arm L/R
☐ Leg L/R

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:	□	□	□	□
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:**

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