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/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

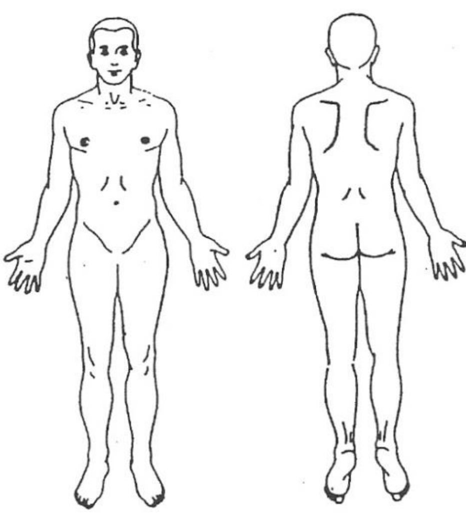
Aggravating:
- ☐ Sitting
- ☐ Walking
- ☐ Standing
- ☐ Bending
- ☐ Lying down
- ☐ Turning your head
- ☐ Moving
- ☐ Coughing/sneezing/straining
- ☐ Other activities/postures: ………………………………….

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

	Present	Past
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

	Present	Past
Bladder problems	☐	☐
Nephritis	☐	☐
Incontinence/inability to control bladder	☐	☐
Urination problems	☐	☐
Blood in urine	☐	☐
Other: …………………..	☐	☐

Do you use:

	Present	Past
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

	Present	Past
Angina Pectoris	☐	☐
Alcoholism	☐	☐
Rheumatism	☐	☐
Tuberculosis	☐	☐
Diabetes	☐	☐
Mononucleosis	☐	☐
Epilepsy	☐	☐
Cancer	☐	☐
Multiple sclerosis	☐	☐
Meningitis	☐	☐
Thyroid disease	☐	☐
Polio	☐	☐
Other:……………….	☐	☐

Skin

Past/Present	Present	Past
Dry skin	☐	☐
Itching	☐	☐
Eczema	☐	☐
Bruise easily/ Skin eruptions	☐	☐
Other: …………….	☐	☐

For women only

	Present	Past
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

	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

	Present	Past
Pain	☐	☐
Altered vision:	☐	☐
☐ Misty		
☐ Blots		
Double vision	☐	☐
Light sensitive	☐	☐
Other:.....................	☐	☐

Ears:

	Present	Past
Pain	☐	☐
Whistle	☐	☐
Loss of hearing	☐	☐
Tinnitus/sound	☐	☐
Noise	☐	☐
Other: ……….. ………………….	☐	☐

Nose/Sinuses

	Present	Past
Pain	☐	☐
Slime	☐	☐
Bleeding	☐	☐
Loss of scent	☐	☐
Chronic congestion	☐	☐
Other: …………	☐	☐

Mouth and throat

	Present	Past
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

Signature: .... **Date:** ....