CHIROPRACTIE RUGKLINIEK HEERLEN

CONFIDENTIAL QUESTIONNAIRE ADULTS (12 years and older)

Please fill in with red

Surname: ……..…..……
Initials: ……..…….……M/F/Other
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)?
…….
…….
…….

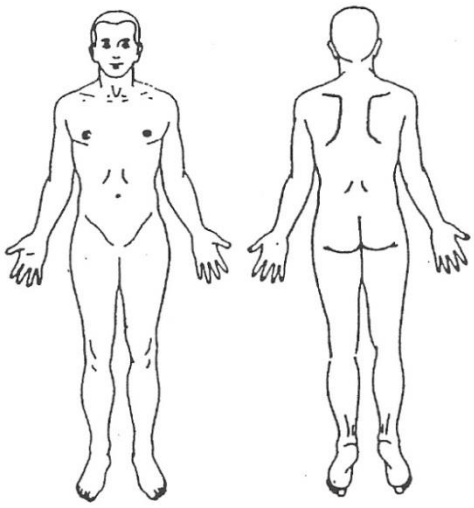
How did your complaint begin?
☐ Gradually
☐ Suddenly
Is your complaint:
☐ Intermittently present
☐ Constantly present
Is there a radiation to:
☐ Arm L/R
☐ Leg L/R

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	□	□
Prostate problems	□	□
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? .....
…….....
……
□ Have you been vaccinated in the past 10 days? (All vaccinations, for travelling) Yes / No

□ 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?

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

Signature: **Date:**

....