Questionnaire

Name: .....
Last Name: .....
Initials: .....
Date of Birth: .....
Address: .....
Postcode: ..... City: .....
Home Telephone: .....
Mobile number: .....
E-mail address: .....

Insurance: .....
Insurance number: .....
BSN number: .....
General Practitioner: .....
Address GP: .....
Occupation: .....
Hobbies / sport: .....
How did you find us: google/specialist: .....

Main Complaint/s:

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

When did the complaint/s start:

.....

How did your complaint/s start:

❑ Suddenly
❑ Gradually
  ❑ constantly present
  ❑ interchangeably present

Is there any radiation into the:

❑ arm L/R
❑ leg L/R

The complaint gets worse with:

❑ sitting
❑ walking
❑ standing
❑ bending
❑ moving
❑ turning your head
❑ cough / sneaze / strain
❑ other activities
.....
.....

The complaint gets better with:

❑ sitting
❑ walking
❑ standing
❑ lying down
❑ movement
❑ other activities
.....
.....

Signs and Symptoms

Muscles and Joints:

past issues
↓ ⌐*current issues*

❑❑ Neck
❑❑ Shoulder L/R
❑❑ Arm L/R
❑❑ Elbow L/R
❑❑ Wrist L/R
❑❑ Hand L/R
❑❑ Vinger/s L/R
❑❑ Rib/s L/R
❑❑ Shoulder blades L/R
❑❑ Low back
❑❑ Pelvis
❑❑ Tailbone
❑❑ Groin L/R
❑❑ Hip L/R
❑❑ Leg L/R
❑❑ Knee L/R
❑❑ Foot L/R
❑❑ Heel L/R

General:

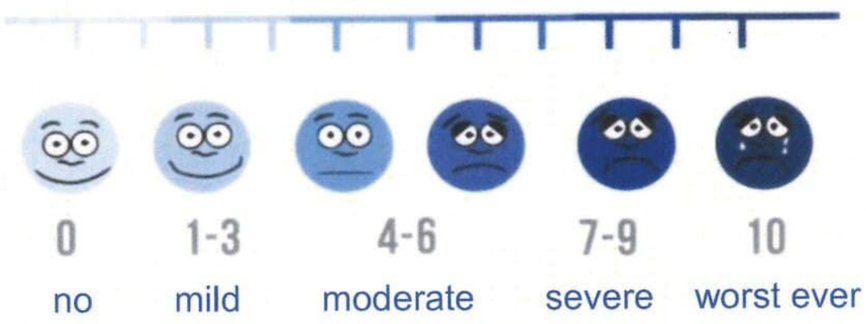
❑❑ Headache
❑❑ Migraine
❑❑ Dizziness
❑❑ Fainting
❑❑ Ringing in ears L/R
❑❑ Sleeplessness
❑❑ Fatigue
❑❑ Low immune function
❑❑ Depression
❑❑ Poor appetite
❑❑ Facial pain
❑❑ Jaw pain
❑❑ Ear/nose/eye and throat problems
❑❑ Sinus problems
❑❑ Ear infection
❑❑ Deafness

Specialist:

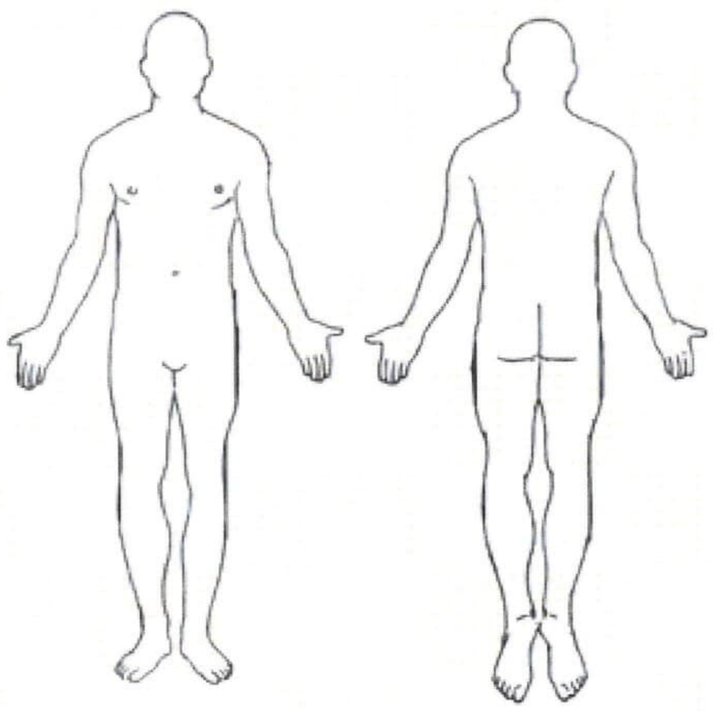
*Have you been und*Beroerteer *care for these complaints at a:*

❑ Chiropractor
❑ General practitioner
❑ Neurologist
❑ Orthopedist
❑ Surgeon
❑ Reumatologist
❑ Physiotherapeut / Manual therapist
❑ Psychologist
❑ Pain Team
❑ Other: .....
.....

Pain measurement:



Indicate where your complaint is:



Front **Back**

Heart and Circulatory:
past issues
↓ ↶ *current issues*
❑❑ Heartproblems
❑❑ Stroke
❑❑ High blood pressure
❑❑ Low blood pressure
❑❑ Varicose veins L/R
❑❑ Poor circulation
❑❑ Swelling in the ankles L/R
❑❑ Anaemia

Lung and Breathing:
❑❑ Breathing difficulties
❑❑ Asthma
❑❑ Lung infection
❑❑ Emphysema
❑❑ Hay fever
❑❑ Pain in the chest
❑❑ Chronic cough
❑❑ Coughing up phlegm/blood
❑❑ Night sweats

Stomach and Intestines:
❑❑ Stomach ache
❑❑ Heartburn
❑❑ Stomach ulcer
❑❑ Stomach or inguinal hernia
❑❑ Galbladder problems
❑❑ Liver problems
❑❑ Constipation
❑❑ Diarrhea
❑❑ Vomit
❑❑ Hemorrhoids
❑❑ Flatulence
❑❑ Bladder problems
❑❑ Kidney problems
❑❑ Prostate problems
❑❑ Uncontrolled urination
❑❑ Appendicitis

Skin:
❑❑ Itching
❑❑ Eczema
❑❑ Bruising
❑❑ Dry skin

Woman:
❑❑ Menopause problems
❑❑ Menstrual cramps
❑❑ Back pain w. menstruation
❑❑ Irregular menstruation
❑❑ Excessive blood loss
❑ Have you had a miscarriage?
❑ Are you potentially pregnant?

Conditions:
❑ Angina Pectoris
❑ Alcoholism
❑ Epilepsy
❑ Cancer
❑ Multiple Sclerosis
❑ Polio
❑ Meningitis
❑ Rheumatism
❑Tuberculosis
❑ Diabetes Type 1 / Type 2
❑ Lyme's disease
❑ Thyroid disease
❑ Other: .....

Physical Stress

Accidents:
.....
.....

Fractures:
.....

Operations:
.....

Hospitilization:
.....

Do you wear any:
❑ Orthotics L/R
❑ Other: .....

How do you sleep:
❑ Back ❑ Side ❑ Stomach

How old is your mattrass:
.....

Hours sitting per day:
❑ 0-2 ❑ 2-4 ❑ 4-8 ❑ >8

❑ Right- or ❑ Lefthanded:

Other physical stress:
.....

Chemical Stress

Medicine you currently taking and why you are taking it:
.....

Alcohol:
❑ severe ❑ normal ❑ moderate ❑ no

Smoking:
❑ severe ❑ normal ❑ moderate ❑ no

Diet:
❑ good ❑ balanced ❑ poor
More info: .....
.....

Liters of water per day:
❑ 0-1 ❑ 1-2 ❑ 2-3 ❑ > 3

❑ Dietary supplements:
.....
.....

Other chemical stress:
.....
.....

Emotional Stress

Work stress:
❑ severe ❑ normal ❑ moderate ❑ no
.....

Financial stress:
❑ severe ❑ normal ❑ moderate ❑ no
.....

Relationship stress:
❑ severe ❑ normal ❑ moderate ❑ no
.....

Depression:
.....
.....

Burn-out:
.....
.....

Other emotional stress:
.....
.....

Other factors affecting your health:
.....
.....
.....

When last did you have these tests:	Shorter than 6 months	Between 6-18 months	longer than 18 months
X-rays/CT/MRI:	❑	❑	❑
Ultrasound	❑	❑	❑
Urine analysis:	❑	❑	❑
Blood analysis:	❑	❑	❑
Cardiovascular exam:	❑	❑	❑
Chiropractic exam:	❑	❑	❑

I am aware that appointments should be canceled at least 24 hours in advance.

Date:
.....

Signature:
.....