DATE: …

Personal data:

Last Name: … Name: … Date of birth: …

Address: … Postal code: … Town: …

Tel. private: … Tel. work: … Tel. mobile: …

E-mail address: … Occupation: …

Partner: …

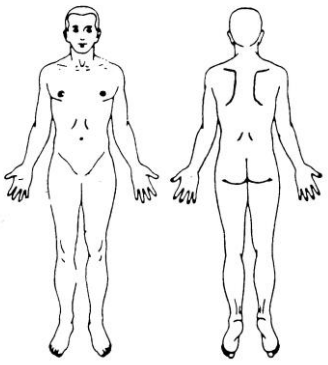
Hobby/Sports: … Insurance company + registration nr.: …

GP (incl. address): ...

How did you find out about our practice? Name: … Internet/Just walked by

What is the reason of your visit to this practice? (Preventive or a specific complaint)

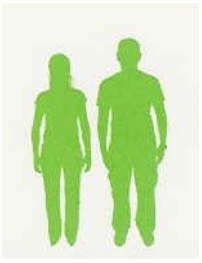
If preventive: do you have a specific question?
…
Have you had any chiropractic care in the past? …
If you have a complaint: could you please describe this?
…
When did you notice this for the first time? …
How is the development of your complaint? (encircle)
the same worse less comes and goes
If different, please describe: …



When does it become apparent? (encircle)
laying down walking sitting bending coughing/sneezing sleeping moving standing still
If different, please describe: ...
What makes your health problem worse ? (encircle)
Laying down walking sitting bending coughing/sneezing sleeping moving sports
If different, please describe: ...
What makes it better ? (encircle)
laying walking sitting bending sleeping moving
If different, please describe: ...
Have you received any other treatment for this complaint? ...
If so: which therapy and when and where?
...
When did you first notice stiffness in the spine? ...
Have you ever had an accident? ...
Have you broken your leg? ...
Do you use orthotics? ....
Have you ever had an operation? ...
If so: what, when and in which hospital?
…
Do you have children? ...
How many and what is their age? ...
Do you suffer from a chronic illness? ...
If so: which illness? ...
Do you suffer from a hereditary or incurable disorder? ...
If so: please describe ...

Encircle all the symptoms listed below that you suffer from? (Even if you don't see the connection with your complaint)

headaches	*hormonal problems*	*eczema*
migraine	*menstrual problems*	*pins and needles in arms*
dizziness	*fever*	*pins and needles n legs*
tinnitus/ear noise	*fainting*	*cold hands*
sinus problems	*insomnia*	*cold feet*
bronchitis	*nervousness*	*heart problems*
stiff neck	*panic attacks*	*bladder problems*
neck pain	*concentration problems*	*constipations or diarrhea*
back pain	*stomach- or digestive problems*	*depression*
Other ...		



How many medications do you use a day and which? …
How much (tap)water do you drink a day? …
Do you eat healthy? …
How much fruit and vegetables do you eat a day? …
How many cigarettes do you smoke a day? ...
How much alcohol do you drink a day/week? ...
How many days a year are you ill? ...
Do you consider yourself healthy?
-if so: why? ...
-if not: why not? ...
What position do you sleep in? (encircle)
side *stomach* *back*

Do you sleep well? ...

How many hours per week:

- do you sit? ...	- Watch T.V. ...
- Ride a car? ...	- Exercise? ...
- Work in front of a computer? ...	- Stroll / walk? ...

How much stress do you have -
- At your work? (Encircle) *none a little normal a lot too much*
- In your free time? (Encircle) *none a little normal a lot too much*

What do you expect from Chiropractic care?
...
What are you currently doing to help yourself?
…
Is there anything else you believe you can do to further help yourself?
...

Your current problem could have originated in your childhood.
The questions below concern <u>your childhood until the age of 18</u>.

Did you suffer from any paediatric diseases? ...
Did you have any vaccinations, if so which ones? ...
Did you take medication as a child? ...
Were you on long-term medication, anti-biotics or inhaler use? …
Did you ever had an operation? No, if Yes what kind of operation...
Have you jumped/fallen from higher than 1 meter? ...
Did you ever had a serious fall? ...
Have you been in a car accident as a child? …
Have you had any other physical, mental or chemical trauma? ...
Did you practise sport as a child? ...
If so: which sport did you practise and at what level? …

Thank you very much for answering the above questions.

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ADVANCED CHIROPRACTIC STUDIO