Questionnaire

Surname: ………………………………………………
Initials: ……………………………………… M / F
First name: …………………………………………
Maiden name: ……………………………………
Date of birth: ………………………………………
Address: ………………………………………………
Postcode: ……………………………………………
City: ……………………………………………………
Phone: …………………………………………………
E-mail: …………………………………………………

Health insurance: ………………………………………….
Insurance no: ………………………………………………
M.D. name: ………………………………………………….
M.D. address: ……………………………………………
Referred by: ………………………………………………..
Occupation: …………………………………………………
Are you working at the present time? Yes / No

Pastime/sports: ……………………………………………
Number of children: ………………………………………..

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
  - o Intermittently
  - o Constantly
- ◻ Suddenly
  - o Intermittently
  - o Constantly

Is there a radiation to:

- ◻ Arm L/R
- ◻ Leg L/R

Aggravating:

- ◻ Sitting
- ◻ Walking
- ◻ Standing
- ◻ Bending
- ◻ Laying down
- ◻ Moving
- ◻ Turning your head
- ◻ Other activities/postures:

………………………………………………

Alleviating:

- ◻ Sitting
- ◻ Walking
- ◻ Standing
- ◻ Bending
- ◻ Laying down
- ◻ Moving
- ◻ Turning your head
- ◻ Other activities/postures:

………………………………………………
………………………………………………

From 1 (light) to 10 (intense), how to estimate your pain?

………………………………………………

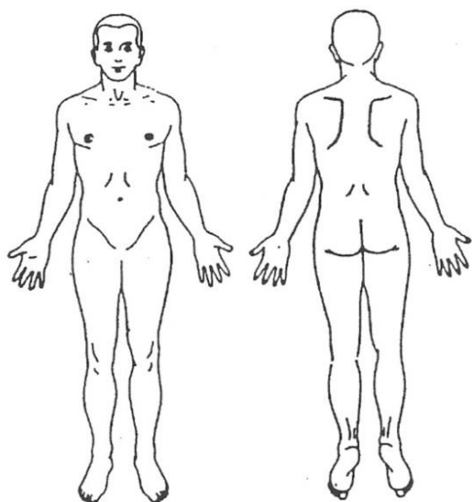
Medical professionals:

Did you see one of these professionals for your complaints:

- ◻ Chiropractor
- ◻ Family doctor
- ◻ Physiotherapist
- ◻ Cesar/mensendieck
- ◻ Manuel therapist
- ◻ Podiatrist
- ◻ Neurologist
- ◻ Rehabilitation doctor
- ◻ Rheumatologist
- ◻ Acupuncturist
- ◻ Surgeon
- ◻ Pain clinic
- ◻ Homeopathic doctor
- ◻ Orthopedist
- ◻ Psychologist
- ◻ Alternative doctors
- ◻ Osteopath
- ◻ Others:

…………………………………
…………………………………
…………………………………

Please specify where your complaint is:



<u>Muscle and joint problems</u>

- ◻ 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
- ◻ Elbow L/R
- ◻ Hand/Wrist L/R
- ◻ Ribs L/R
- ◻ Bursitis
- ◻ Swollen joints
- ◻ Arthritis
- ◻ Gout
- ◻ Muscle weakness

<u>General</u>

- ◻ Headache
- ◻ Migraine
- ◻ Dizziness:
  - O I spin
  - O The room spins
- ◻ Fainting
- ◻ Fits of rage
- ◻ Difficulty sleeping
- ◻ Concentration problems
- ◻ Memory loss
- ◻ Anxiety/Fear
- ◻ Exhaustion
- ◻ Nervousness
- ◻ Depression
- ◻ Loss of appetite
- ◻ Allergies
- ◻ Sinusitis
- ◻ Facial pain L/R
- ◻ Tremor (rest or moving)

Date of last tests	<6 mnts	6-18 mnts	>18 mnts	never
Urine test	◻	◻	◻	◻
X-ray/CT/MRI	◻	◻	◻	◻
Blood test	◻	◻	◻	◻
Chiropractic examination	◻	◻	◻	◻
Cardiac examination	◻	◻	◻	◻

Habits	Heavy	normal	moderat	none
Appetite	◻	◻	◻	◻
Coffee	◻	◻	◻	◻
Alcohol	◻	◻	◻	◻
Exercise	◻	◻	◻	◻
Sleep	◻	◻	◻	◻
Smoking	◻	◻	◻	◻

- ◻ Accidents: ………………………………………………………………………………………
- ◻ Bone fractures: ………………………………………………………………………………
- ◻ Surgical operation: …………………………………………………………………………
- ◻ Hospitalizations: ……………………………………………………………………………
- ◻ Emotional disorders: ………………………………………………………………………
- ◻ Medications and for: ………………………………………………………………………
- ◻ Nutrient vitamins and minerals? Which?: ………………………………………

Date:

……………………………………………

Signature:

……………………………………………

Have you been vaccinated in the past 10 days?
Yes/No

May we contact or inform your M.D.?

Yes / No *

* Circle as appropriate. If nothing is circled, we reserve the right to inform your M.D.

Information and consent form

With this form you will be informed of our privacy policy, the general and cancellation conditions, the benefits of a chiropractic treatment, but also of any side effects and risks and finally the alternatives, so that you can then make an informed decision based on that. with regard to your chiropractic treatment.

Privacy

If you are treated at our practise you automatically give permission to process the personal data in accordance with our privacy policy. If you only request information in a personal conversation and do not undergo treatment, you give permission to save your personal data by signing this form. Your personal data won't be shared with third parties.

Cancellation

If, due to circumstances, you cannot keep your appointment, you can of course change your appointment. However, you must indicate this at least 24 hours in advance. This gives us the opportunity to offer your appointment time to others in a timely manner. Cancellations that are passed on too late, as well as missed appointments, will be charged.

Compensation

Almost all health insurance companies reimburse chiropractic care. However, the % of the reimbursements can vary. Ask your own health insurer about the conditions.

Chiropractic treatment

A chiropractic treatment involves correcting, manipulating and mobilizing the joints in the spine and other joints in the body. Muscle techniques such as trigger point therapy and other forms of therapy are also used, such as exercises and advice on posture and nutrition.

Benefits

Chiropractic treatments have been proven effective for musculoskeletal complaints. Treatment by your chiropractor can reduce pain, including back pain and headache, changes in sensation, muscle cramps, and stiffness. The treatment can increase your freedom of movement, improve movement functions, reduce or prevent the use of (pain) medication and make medical interventions unnecessary.

Possible side effects

Chiropractic is a very safe treatment method. The chance of adverse effects is minimal. However, side effects very occasionally vary from person to person (depending on the condition and health status) and the type of treatment being performed. We are required by law to make this known to you before you agree to the proposed treatment.

Side effects can be:

• Occurs regularly: Temporary worsening of symptoms.

Normally, an exacerbation of pre-existing complaints of stiffness and sensitivity only takes a few hours to a few days at most.

• Very uncommon: Muscle / tendon contusion.
Normally a muscle / tendon strain or bruise will go away by itself within a few days to weeks, with a period of rest and relief of the affected area.

• Rare: Rib bruise**.**
Although painful and restrictive for daily activity, a bruised rib and it generally recovers automatically within a few weeks.

• Very exceptional:
Serious complications are very exceptional within the chiropractic. Due to the rarity, it is difficult to determine whether a worsening of symptoms by the treatment or is part of the natural course of the complaint. For example: a hernia that unexpectedly causes disorder / failure in the legs, bladder or intestines, which may require surgery.

• Extremely rare: stroke.
In extremely rare cases, a patient has a dissection of a blood vessel in the neck. A dissection is a release from the inside of the blood vessel. In the worst case, this can lead to a closure (stroke) with all possible consequences, such as permanent disability or death. A dissection is often not recognized before symptoms of a stroke occur. A dissection can be expressed at any time during normal everyday exercise, such as coughing, sneezing, looking around, looking up, exercising and neck treatments. According to science, these movements are not the cause of the dissection. The underlying cause of the dissection is not yet known. The chance that a stroke will manifest itself after a neck treatment is estimated at no more than one in a million (0.0001%). Current scientific evidence has established that chiropractic treatment does not increase the risk of damage to an artery or stroke.

Alternatives
Your chiropractor masters various treatment techniques that are adapted to your personal situation. A treatment plan will be drawn up for you. If you have questions about the techniques that your chiropractor uses, feel free to ask your chiropractor. Of course you can opt out of treatment at any time. Alternatives to chiropractic may include: pain relief or other (para) medical assistance.

Questions, concerns or comments
If you have any questions, concerns or comments, you can of course discuss them with your chiropractor at any time. Your care is our concern. Always inform your chiropractor if there are changes in your symptoms or illness.

□ I agree with the privacy policy and the general and cancellation conditions
□ I have been informed about my complaints and about the possible treatment thereof
□ I understand what the treatment entails and I have been able to ask all my questions
□ I have considered all the benefits and possible side effects of the treatment, as well as the alternatives
□ I agree with the proposed treatment plan. (explained after first treatment)

Place date:_______________________________________
Name: ____
Clients signature {e}: _____________________________
* If underage (<16 years), signature parent / guardian