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
  - ○ Intermittently
  - ○ Constantly
- ☐ Suddenly
  - ○ Intermittently
  - ○ 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?

……

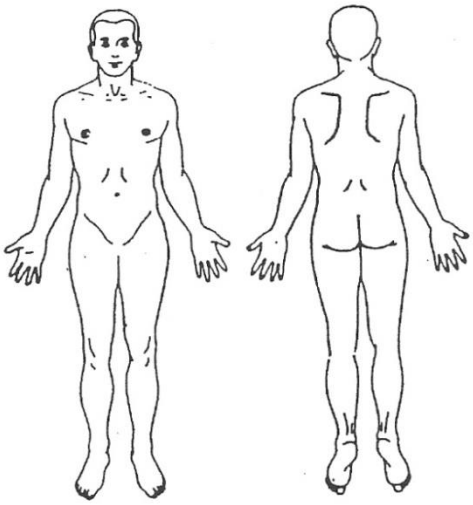
Medical professionals:

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:



Muscle and joint problems

- □ 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

General

- □ 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.