Osteopathie Praktijk Dana

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Date:	
Time:	

Could you please carefully read the following questions and answer them as much as possible? This will be discussed during the initial consultation with you.
Please send or mail this form to the above (E-mail) address preferably before the first treatment.
Your data shall be confidential and remain private. Thank you for your cooperation.

Surname:		First name:	
Initials:		Date of birth:	
Address:		Zip code:	
City:		Informed by:	
Telephone number:		Mobile:	06-
Email address:			
Profession:		Medication:	
Sport's, Hobby's:			
Family physician (GP):			
Full address:			
Telephone number:		Specialist:	
Is there other research done?		If so, what were the findings?	
X-ray, MRI, CT, blood / laboratory:		Other?	

☐	GP / doctor is not aware of your visit to an osteopath
☐	I object reporting to GP / doctor

What is your main complaint?	
When did it start?	
Under what circumstances?	
What are currently the additional complaints:	1.
	2.
	3.
Have you previously been treated by a physiotherapist, manual therapist, chiropractor or an alternative healer (e.g. mesologist, homeopath, acupuncturist)? If so, what where the complaints?	
Which illness was the most difficult in your life so far?	
Which illness, accident or surgery was the last before your current symptoms started?	

If you have pain, can you describe it: nagging, shooting, burning, throbbing, stabbing, oppressive, etc.:	
Is there a pattern or regularity to notice into your complaints? (morning / afternoon / evening / night)	
What aggravates your problem(s)? (strong physical/psychological stress, climate change, fever, menstruation):	
What gives improvement? (for instance: cold, heat, rest, attitude, food, movement):	
How do you feel in general: tired, hunted, active, passive, depressed, excited:	
Are there moments in a day of breakdown?	
Do you awake at night? If so, what time:	Yes / No* make a choice... , time:
How is your bowel movement? Frequency:	x daily / x per week Regularly / irregular * make a choice...
Consistency:	aqueous / solid / hard / greasy * make a choice... Additional explanation:
Colour: grey / light brown / dark brown / black	
Loss of blood during defecation:	
Which food or spices cause you difficulty in digesting?	
Do you have a great craving for sweets?	Yes / No * make a choice...
How much water do you drink a day?	
Are you using milk products?	
Are you smoking? How much?	
Do you drink alcohol? How much?	
Do you use drugs? What kind and how often?	
Do you drink coffee? How much? With milk or sugar?	

Familial diseases: Do you have in your family genetic and/or familial disorders (heart disease, arthritis, diabetes, cancer)?	
Mother:	
Father:	
Other:	

Would you please indicate which items you apply? The left column is for the old complaints, the right column for recent complaints. If you had current symptoms even earlier, then tick both columns. When you have a * please make a choices.

General

☐ ☐ Headache: daily/weekly/monthly*
Make a choice
Which part of the head? .....
☐ ☐ Poor sleep
☐ ☐ Difficulty falling asleep
☐ ☐ Substantial weight change: weight gain/loss*
make a choice
☐ ☐ Dizziness
☐ ☐ Fatigue:
continuous/morning/afternoon/evening*
make a choice
☐ ☐ Double/blurred vision
☐ ☐ Allergy .....

Respiratory

☐ ☐ Dyspnoea
☐ ☐ Chronic cough
☐ ☐ Chronic cold
☐ ☐ Asthma
☐ ☐ Sore throat/inflammation
☐ ☐ Sinusitis
☐ ☐ Tinnitus

Heart and blood vessels

☐ ☐ High/low blood pressure* make a choice
☐ ☐ Swollen glands
☐ ☐ Arteriosclerosis
☐ ☐ Irregular heartbeat
☐ ☐ Chest pain/chest tightness * make a choice
☐ ☐ Palpitations
☐ ☐ Cold hands/feet* make a choice
☐ ☐ Varicose

☐ ☐ Fluid retention

Urine tract

☐ ☐ Kidney stones/infection* make a choice
☐ ☐ Pain during urinating
☐ ☐ Prostate problems
☐ ☐ Bladder inflammation
☐ ☐ Sexually transmitted disease
☐ ☐ Change in urine
☐ ☐ Change libido

Women

Pregnant yes/no* make a choice
Age first menstruation .....
☐ ☐ Painful menstruation
☐ ☐ Irregular menstruation
☐ ☐ Prolonged menstruation
☐ ☐ Breast pain
☐ ☐ Premenstrual syndrome
☐ ☐ Menopause
☐ ☐ White secretion
☐ ☐ Pain/irritation vagina

Stomach / intestines

☐ ☐ Intestinal inflammation

☐ ☐ Constipation
☐ ☐ Diarrhoea
☐ ☐ Dry mouth

☐ ☐ Bloated feeling
☐ ☐ Abdominal pain/cramps*
make a choice

☐ ☐ Flatulence
☐ ☐ Nausea
☐ ☐ Gurgling stomach
☐ ☐ Stomach acid
☐ ☐ Ulcer
☐ ☐ Other.....

Muscles / Joints

☐ ☐ Tense/weak muscles* make a choice
☐ ☐ Low back pain
☐ ☐ Neck pain
☐ ☐ Nerve tingling/radiance*
make a choice
☐ ☐ Joint pain
☐ ☐ Muscle pain/cramps * make a choice
☐ ☐ Movement restriction
☐ ☐ Rheumatism (by physician)

Skin

☐ ☐ Eczema/rash* make a choice
☐ ☐ Quick bruising
☐ ☐ Dry skin/excessive transpiration*
make a choice
☐ ☐ Itching
☐ ☐ fast-breaking nails
☐ ☐ Hair loss/breaking hair* make a choice

Mental state

☐ ☐ Nervous
☐ ☐ Depression
☐ ☐ Worrying
☐ ☐ Concentration weakness
☐ ☐ Memory reduction
☐ ☐ Anxiety
☐ ☐ Apprehensive

☐ ☐ Lethargy
☐ ☐ Introvert
☐ ☐ Low self esteem
☐ ☐ Sorrow, sadness
☐ ☐ Indecisive
☐ ☐ Irritated
☐ ☐ Hot flashes
☐ ☐ Other: .....

Health and disease History

Can you please write as much as possible in chronological order:

1. Which illnesses, surgeries, accidents and treatments have you undergone in your life. Even small things like sprains, dental treatments, tonsils, eczema, allergies, etc.
2. Childhood disease
3. Important or significant periods (divorce, death, depression, arched, etc.)
4. Pregnancy (s) and their progress
5. Stay abroad outside of Europe and any vaccinations

If you need more space, please add an extra page.

Age	**illnesses / complaint / pregnancy / development**