Osteopathie Praktijk Dana

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Date:	
Time:	

Dear Ms, Mr,
Please read the following questions carefully and answer them as accurately as possible. At * make a choice from the menu on the computer or print the form and cross out what does not apply.
The details will be discussed with you during the intake interview. Naturally, the data will remain strictly confidential. Thanks for your effort.

Surname		Name	
Gender	Girl/Boy*Make a choice...,		
Address		Zip code	
City		Date of birth	
Name of parents/guardians			
Phone number		GSM	06-
E-mail address			
School/nursery		Class	
Sports, Hobbies, Leisure			
Medication use			
Supplements and Vitamins			
General practitioner		Phone number	
Specialist		Phone number	

☐	I do not object to sending a report to my doctor or general practitioner
☐	I am willing, one year after the treatments, to answer questions about the satisfaction with the treatments and the result achieved

Who informed / advised you?	
What is your child's main complaint?	
When did this complaint start and under what circumstances?	
How does your child make his / her complaint known?	
Is there a regularity or pattern in your child's complaints?	
Which circumstances provide improvement? (e.g. cold, heat, rest, stress, hunger, food, posture, movement)	
Aggravation?	
What has been done about this complaint before?	
Apart from the above information, has your child ever been treated by a physiotherapist, manual therapist, specialist or an alternative healer (for example, homeopath, iridologist, acupuncturist, magnetizer)	

Are there any additional complaints besides the main complaint?	1.
	2.
	3.
How is the family composition? Brothers, sisters, (co-) parents, etc.	
What is the child's position within the family composition? (1st, 2nd, etc.)	

Did your child's pregnancy go well? If not, what and when did it not go well?	
Did you take any medication during your pregnancy? If yes which one? What for and when?	
How did the delivery go? Difficult, long, fast? Before or after the due date?	
Was childbirth provoked? Introduced? Delayed?	
Was pressed or pushed on your stomach during labor?	
Did your child clearly cry/scream at birth?	
Was he/she born in a breech position?	
Has vacuum/spatula/forceps been used?	
Is it a caesarean section? Planned/not planned?	
Are you breastfeeding your child?	
Does your child spit after eating? How much?	
What vaccinations did your child have?	
How is the bowel movement? Frequency?	x daily / x per week regular / irregular * Make a choice...
Consistency: solid/pulpy/soft/watery	solid / slurry / soft / watery * Make a choice... Additional explanation:
Color: white/light brown/yellow brown/ dark brown/black/ green	Color * Make a choice...
Which foods and/or drinks make your child react badly?	
Does he/she have a great need for sweets?	Yes/No* Make a choice...
Does he/she use dairy?	
How much water does he/she drink per day?	
Does your child have allergies and/or hypersensitivity to cow's milk protein, lactose, gluten, soy, fruits, hay fever, insects, medicines, etc.?	
What time does your child go to bed?	

Does he/she fall asleep easily?	
Does he/she wake up at night? What time?	Yes/No* Make a choice...
Is he/she toilet trained during the day?	
Is he/she toilet trained at night?	
Does he/she have completed primary teeth?	
Is he/she already changing teeth?	
Does your child like to play alone, together, indoors, outdoors?	Yes/No* Make a choice...
Does your child cry a lot?	Yes/No* Make a choice...
How many hours per day?	
Is there a pattern to be discovered? When does he/she cry?	

Familial diseases: Hereditary disorders (cardiovascular diseases, rheumatism, cancer, diabetes, skin disorders, etc.) and non-hereditary disorders	
Mother:	
Father:	
Other family members:	

Please tick below which points apply to your child:

- ☐ Afraid of being alone
- ☐ Cries quickly
- ☐ Frightened
- ☐ Testily
- ☐ Angry
- ☐ Jealous
- ☐ Concentration weakness
- ☐ Eczema/rash
- ☐ Flatulence
- ☐ Diarrhea
- ☐ Reflux
- ☐ Asthma/bronchitis
- ☐ Cramped
- ☐ "Mother's child"
- ☐ Likes to cuddle
- ☐ Does not like to cuddle
- ☐ Cheerful
- ☐ Hyperactive
- ☐ Slow
- ☐ Alert
- ☐ Abdominal pain/cramps
- ☐ Rumbling stomach
- ☐ Constipation
- ☐ Ear pain/inflammation
- ☐ Chronic cold
- ☐ Short of breath

Please describe as chronologically as possible (child related):
1. What illnesses, operations, accidents and treatments you have gone through in your life. Apparently minor things like sprains, dental treatments, peeling tonsils and eczema can also be important
2. The childhood illnesses you have had
3. Possible pregnancies and their course
4. Major developments in your life can also have an influence (divorce, exhaustion, depression, etc.)
5. Visits abroad (outside Europe)

Age	**Illness / complaint / pregnancy / development**

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

From May 25, 2018, the new privacy law (General Data Protection Regulation - AVG) has been introduced. To be able to comply with this, you will be asked after completing the intake form to fill in the tick X where you indicate in writing that you have taken note of the privacy policy, as you can find on my website under AVG. In this way, you also give consent to the osteopath, Dana Yelnik, the opportunity to gain insight into your personal information and your medical history and to create a client file.

I give Osteopathy Praktijk Dana permission to use my data: ☐