

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?	

<input type="checkbox"/>	GP / doctor is not aware of your visit to an osteopath
<input type="checkbox"/>	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 were 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.

- | | |
|--|---|
| <p>General</p> <p><input type="checkbox"/> <input type="checkbox"/> Headache: daily/weekly/monthly*
Make a choice
Which part of the head?</p> <p><input type="checkbox"/> <input type="checkbox"/> Poor sleep</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty falling asleep</p> <p><input type="checkbox"/> <input type="checkbox"/> Substantial weight change: weight gain/loss*
make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue:
continuous/morning/afternoon/evening*
make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Double/blurred vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergy</p> <p>Respiratory</p> <p><input type="checkbox"/> <input type="checkbox"/> Dyspnoea</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic cold</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Sore throat/inflammation</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Tinnitus</p> <p>Heart and blood vessels</p> <p><input type="checkbox"/> <input type="checkbox"/> High/low blood pressure* make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen glands</p> <p><input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain/chest tightness * make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> <input type="checkbox"/> Cold hands/feet* make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Varicose</p> <p><input type="checkbox"/> <input type="checkbox"/> Fluid retention</p> <p>Urine tract</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney stones/infection* make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain during urinating</p> <p><input type="checkbox"/> <input type="checkbox"/> Prostate problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Bladder inflammation</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexually transmitted disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Change in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Change libido</p> <p>Women</p> <p><input type="checkbox"/> <input type="checkbox"/> Pregnant yes/no* make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Age first menstruation</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful menstruation</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular menstruation</p> <p><input type="checkbox"/> <input type="checkbox"/> Prolonged menstruation</p> <p><input type="checkbox"/> <input type="checkbox"/> Breast pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Premenstrual syndrome</p> <p><input type="checkbox"/> <input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> <input type="checkbox"/> White secretion</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain/irritation vagina</p> | <p>Stomach / intestines</p> <p><input type="checkbox"/> <input type="checkbox"/> Intestinal inflammation</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhoea</p> <p><input type="checkbox"/> <input type="checkbox"/> Dry mouth</p> <p><input type="checkbox"/> <input type="checkbox"/> Bloating feeling</p> <p><input type="checkbox"/> <input type="checkbox"/> Abdominal pain/cramps*
make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Flatulence</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Gurgling stomach</p> <p><input type="checkbox"/> <input type="checkbox"/> Stomach acid</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> <input type="checkbox"/> Other.....</p> <p>Muscles / Joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Tense/weak muscles* make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Nerve tingling/radiance*
make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle pain/cramps * make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Movement restriction</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatism (by physician)</p> <p>Skin</p> <p><input type="checkbox"/> <input type="checkbox"/> Eczema/rash* make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Quick bruising</p> <p><input type="checkbox"/> <input type="checkbox"/> Dry skin/excessive transpiration*
make a choice</p> <p><input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> fast-breaking nails</p> <p><input type="checkbox"/> <input type="checkbox"/> Hair loss/breaking hair* make a choice</p> <p>Mental state</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervous</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Worrying</p> <p><input type="checkbox"/> <input type="checkbox"/> Concentration weakness</p> <p><input type="checkbox"/> <input type="checkbox"/> Memory reduction</p> <p><input type="checkbox"/> <input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> <input type="checkbox"/> Apprehensive</p> <p><input type="checkbox"/> <input type="checkbox"/> Lethargy</p> <p><input type="checkbox"/> <input type="checkbox"/> Introvert</p> <p><input type="checkbox"/> <input type="checkbox"/> Low self esteem</p> <p><input type="checkbox"/> <input type="checkbox"/> Sorrow, sadness</p> <p><input type="checkbox"/> <input type="checkbox"/> Indecisive</p> <p><input type="checkbox"/> <input type="checkbox"/> Irritated</p> <p><input type="checkbox"/> <input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> Other:</p> |
|--|---|

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

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: