* **Intake form adult: Osteopathie Praktijk De Vos**

Dear Sir, Madam,

Please read the questions below carefully and answer them as accurately as possible. We wil discuss this information during the first consultation. Naturally all information is strictly confidential and patients’records will be kept according to statutory regulations. Thank you.

Surname : Christian name :

Address : Postal code :

Place of residence: Date of birth:

Tel (mobile): E-mail address:

Civil service number:

Occupation : Previous occupations:

Sports, hobby, leisure :

Use of medication :

G.P : Place of residence:

* I object to sending a report to my G.P.

Who informed/advised you? :

What is the principal complaint?

When did this complaint start and under what circumstances?

Indicate where it hurts and mark scars (if any) in red in these drawings

Can you describe the nature of the ache (e.g. stabbing, burning, nagging, shooting, etc.):

Is there a pattern or regularity in your complaints?

What circumstances lessen the complaints? (e.g. cold, warmth, rest, more stress, food, posture, movement):

And what worsens them?

How do you feel in general? (sad, anxious, restless, irritated)

Are there moments of dejection during the day?

Do you wake up at night, what time?

How is your bowel movement? x daily / x weekly. Regular / Irregular

Consistency: firm/ gooey/ soft/ watery. Colour: white/ lightbrown/yellowish/ darkbrown/ black

Do you have a preference or aversion for sweet, sour, spicy, bitter?

Preference: Aversion:

What kind of foods or drink do not agree with you?

Do you crave sugar? YES/NO

Do you smoke, if so, how much:

Do you drink alcohol, if so, how much?

Do you take drugs, if so, which and how often?

Do you drink coffee, if so, how much?

Do you take dairy products, if so, how much?

Apart from the reason for this consultation, are there any new, recent complaints?

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2

3

Family illnesses: hereditary and non-hereditary illnesses?

Mother:

Father:

Other relatives:

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| --- | --- |
| ***General***⭘ ⭘ Headache: daily/ weekly / monthly \*Where in the head ?:⭘ ⭘ Insomnia⭘ ⭘ Sleeping badly⭘ ⭘ Weight change: Increase / Decrease \*⭘ ⭘ Dizziness⭘ ⭘ Fatigue: continuous/morning/afternoon/evening \*⭘ ⭘ Double vision/blurred vision⭘ ⭘ Allergy::***Airways/throat/nose/ear***⭘ ⭘ Shortness of breath⭘ ⭘ Chronic coughing⭘ ⭘ Chronic colds⭘ ⭘ Asthma ⭘ ⭘ Sore throats/laryngitis⭘ ⭘ Sinusitis⭘ ⭘ Tinnitus***Heart and bloodvessels***⭘ ⭘ High/low blood pressure \*⭘ ⭘ Swollen glands⭘ ⭘ Arteriosclerosis⭘ ⭘ Irregular heartbeats / palpitations \*⭘ ⭘ Pain / constriction in the chest \*⭘ ⭘ Cold hands and/or feet \*⭘ ⭘ Varicose veins: ⭘ ⭘ Fluid retention***Urinary passages***⭘ ⭘ Kidney infection / kidney stones \*⭘ ⭘ Pain when passing water⭘ ⭘ Prostate complaints⭘ ⭘ Bladder infection⭘ ⭘ Venereal disease⭘ ⭘ Change in urine⭘ ⭘ Change of libido***Women***Age of 1st menstruation:⭘ ⭘ Painful menstruation⭘ ⭘ Irregular menstruation⭘ ⭘ prolonged menstruation⭘ ⭘ Painful breasts⭘ ⭘ Endometriosis⭘ ⭘ Other: Pregnant YES / NOMenopause YES / NO | ***Stomach and intestines***⭘ ⭘ Gastroenteritis⭘ ⭘ Constipation⭘ ⭘ Diarrhoea⭘ ⭘ Dry mouth ⭘ ⭘ Bloated belly⭘ ⭘ Nausea⭘ ⭘ Flatulence⭘ ⭘ Abdominal pains/cramps \*⭘ ⭘ Heartburn⭘ ⭘ Haemorrhages⭘ ⭘ Other***Muscles and joints***⭘ ⭘ Tensed/weak muscles\*⭘ ⭘ Lower back pain⭘ ⭘ Pain in the neck⭘ ⭘ Tingling / radiating pain⭘ ⭘ Aching joints⭘ ⭘ Muscular pain / cramp \*⭘ ⭘ Restricted movement⭘ ⭘ Rheumatism***Skin***⭘ ⭘ Eczema / rash \*⭘ ⭘ easily bruising ⭘ ⭘ Dry skin⭘ ⭘ Excessive transpiration ⭘ ⭘ Itch⭘ ⭘ Brittle nails⭘ ⭘ Loss of hair / brittle hair \****Mental constitution***⭘ ⭘ Nervousness⭘ ⭘ Depressions⭘ ⭘ Overly concerned⭘ ⭘ Loss of concentration⭘ ⭘ Memory losses⭘ ⭘ Anxiety⭘ ⭘ Worrying, fretting⭘ ⭘ Listlessness⭘ ⭘ Bottling up⭘ ⭘ Little self-confidence⭘ ⭘ Grief, sadness⭘ ⭘ Indecisiveness⭘ ⭘ Irritable⭘ ⭘ Hot flushes⭘ ⭘ Other: |

Please indicate on this page which topics apply to you

The left column is for **old** complaints , the right column is for **recent** complaints

\*In case of multiple choice, cross out what does not apply to you

***Pathological history***

Could you describe as chronological as possible:

* Which illnesses you have had, operations and treatments, including small matters like sprains, dental treatment, eczema etc.
* Childhood illnesses
* Pregnancies and their courses
* Important developments in your life (divorce, burn-out, depressions, loss of loved one, etc)
* Visits abroad (outside Europe)

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| --- | --- |
| Age | ILLNESS/COMPLAINT/PREGNANCY/COURSE |
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Apart from the above-mentioned, have you ever been treated by a physiotherapist, manual therapist, specialist or alternative healer (e.g. homeopath, chiropractor, acupuncturist?

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Which illness or important development in your life was the most fundamental ?

What was the last illness, accident, operation before the present complaints began?

Does strong physical or psychological stress, change of climate, fever, menstruation etc. increase the complaint ?