BrusselsChiropractic

Confidential Patient Information

Last Name: ______________________

First Names: ______________________

Date of Birth: ______________________

Address: ______________________

____

Postcode: ______________________

Nationality: ______________________

Telephone (home): ______________________

Telephone (mobile): ______________________

Telephone (work): ______________________

Email: ______________________

How did you hear of the clinic?

____

Occupation: ______________________ Currently Working? Yes / No / Less than normal

What do/did you do precisely for work? (eg. 20% driving, 30% lifting, 50% office)

____

Hobbies: (eg. reading 2 hours per day, running 1 hour, 3x/week)

____

Marital Status: ______________ Age of children (if any): ______________________

General Medical Doctor: ______________________

Address: ______________________

When was your last visit to your doctor? ______________________

When were you last at the hospital? ______________________

Operations: ______________________

____

Accidents or falls: ______________________

____

Current/Previous medications: ______________________

____

Do we have your permission to discuss with your medical doctor or other specialist? Yes / No

Belgian Mutuality (i.e. insurance company): ______________________

Supplementary/International Health Insurance: ______________________

Height: __________ Weight: __________ Recent weight changes: ______________________

Do you currently have, or have you previously had, any problems with the following?

Arthritis: ______________________

Kidneys/Bladder: ______________________

Stomach/Intestines: ______________________

Lungs: ______________________

Ears: ______________________

Eyes: ______________________

Vertigo/Dizziness: ______________________

Mouth/Throat: ______________________

Nose/Sinus: ______________________

Depression: ______________________

Diabetes: ______________________

Blood Pressure: ______________________

Heart or Circulation Problems: ______________________

____

Menapause Problems: ______________________

Menstrual Pain/Problems: ______________________

Sleep Disorders: ______________________

Other Health Concerns: ______________________

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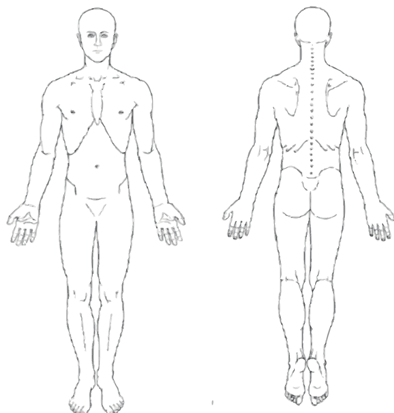
Complaint 1

When was the first time it occurred? ____________

Draw on the diagram the location of the problem:



☐ ache ☐ burning ☐ sharp
☐ cramping ☐ stiffness ☐ numbness
☐ constant ☐ daily ☐ periodic

How serious is the pain?

0 1 2 3 4 5 6 7 8 9 10

How is it affecting your life?

0 1 2 3 4 5 6 7 8 9 10

How did the problem begin?

☐ gradually ☐ suddenly

What was the cause, if you know it?

____

What makes it worse?

☐ Sitting ☐ Lying ☐ Walking
☐ Moving ☐ Standing ☐ Bending
☐ Turning head ☐ Coughing/Sneezing
☐ ____________________________

What makes it better?

☐ Sitting ☐ Lying ☐ Walking
☐ Moving ☐ Standing ☐ Bending
☐ Sport ☐ Special Exercises
☐ ____________________________

Have you already had treatment?

☐ Chiropractor ☐ Medical Doctor
☐ Neurologist ☐ Physio/Kinetherapist
☐ Acupuncture ☐ Orthopaedic Specialist
☐ Other: ____________________

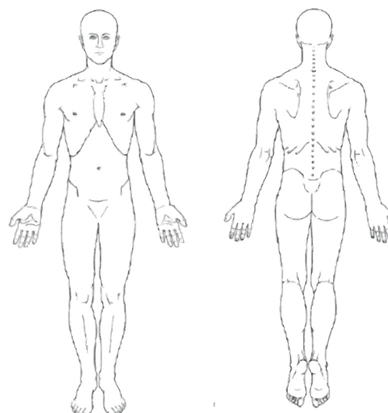
Investigations:

☐ X-rays/MRI: ____________________
☐ Blood Tests: ____________________

Complaint 2

When was the first time it occurred? ____________

Draw on the diagram the location of the problem:



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☐ Chiropractor ☐ Medical Doctor
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☐ Acupuncture ☐ Orthopaedic Specialist
☐ Other: ____________________

Investigations:

☐ X-rays/MRI: ____________________
☐ Blood Tests: ____________________

Other Conditions: ____________________________

Signed: ____________________ Date: ____________