Dear Sir / Madam,

Welcome to North Sea Chiropractic. It is our aim that your experience in our office is always pleasant, cheerful and that the service we provide is of the highest quality. Chiropractic therapy has helped millions of people worldwide, of all ages, improve their quality of life. We look forward to helping you improve your health with the best standard of care possible.

Your first appointment

During the first consultation, a comprehensive health history is taken followed by a physical examination. Please allow up to an hour for this appointment. We kindly ask you to fill out the enclosed questionnaire, front and back, and bring it, along with your insurance card, to your first appointment.

** Please also bring a towel with you to each visit.

Payment

The cost of the first visit is 90 euro. For the follow-up consultations, the cost is 60 euro. Payments are made immediately after treatment by either PIN card or cash. You will receive a receipt for insurance purposes. Most health insurances (above basic level) cover at least part of the chiropractic treatment. The reimbursements vary per insurance company, therefore we advise you to check in advance with your insurance company regarding their policy on chiropractic.

If an appointment needs to be cancelled or rescheduled, it must be done with at least 24 hours notice. This policy allows us time to reschedule the vacant slot for other patients. Any appointments that are cancelled with less than 24 hours advance notice, as well as missed appointments, will be charged 60 euro. When we are unavailable by phone, please leave a message on the voicemail stating your name and phone number and we will return your call, if necessary, as soon as possible.

If you have any questions, please see our website at www.chiropractienoordzee.nl for more information, or you can contact us at: 06-5369 77 39, or via email at: chiropractienoordzee@gmail.com.

Sincerely,

Ceci Wong, D.C., CACCP
Thomas Halyk, B.A, D.C., DACBSP, ICSC, CSCS, EMT-B
Chiropractors, North Sea Chiropractic

North Sea Chiropractic

Confidential Patient History

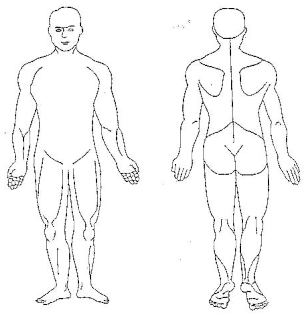
Please complete this questionnaire and bring it to your first appointment.

Surname: _____ First name: _____
Date of Birth: _____ Married/Single/Living together/Widow Children: _____
Address: _____
Post code: _____ City: _____ Email: _____
Telephone (work): _____ Telephone (mobile): _____
Do you work: Yes / No If yes, (your) Occupation (is): _____
Name of Physician: _____ May we inform your physician over the course of your treatment? Yes/No
Address and telephone of Physician: _____
Health Insurance: _____ Insurance Number: _____
BSN# (required): _____ May we add you to our mailing list? Yes / No
How did you hear about North Sea Chiropractic: physician specialist advertisement internet
other, please list: _____

Current/Present Complaint:

1. What is your primary complaint(s)? Please mark on the drawing where exactly you have pain.

- □ Headaches/Migraines
- □ Neck complaints
- □ Whiplash/post accident complaints
- □ Pain in shoulders/between shoulder blades
- □ Complaints arising from heavy work
- □ Pain in the low back/pelvis
- □ Tingling or numb extremities
- □ Sports injury
- □ Degeneration/Arthritis
- □ Stiffness
- □ RSI complaint
- □ Poor sleep
- □ Muscle tension
- □ Other: _____



2. When did the above mentioned complaint start?

□ Days □ Weeks □ Months □ Years □ My whole life

3. What is the possible cause of this complaint?

□ Auto accident □ Fall □ Work □ Other: _____ □ I don't know

4. How did this complaint begin?

□ Slow onset – variable or present constantly □ Suddenly – variable or present constantly

5. This complaint is getting:

□ Better □ Worse □ Staying the same

6. Have you ever had this complaint before? Yes / No

7. Have you (previously) been under treatment for this complaint by one or more of the following therapists/specialists?

- □ Chiropractor
- □ Neurologist
- □ Pain clinic
- □ Physician
- □ Homeopathic doctor
- □ Physiotherapist
- □ Rheumatologist
- □ Orthopedist
- □ Posture specialist
- □ Acupuncturist
- □ Psychologist/Psychiatrist
- □ Rehabilitation specialist
- □ Manual therapist
- □ Surgeon
- □ Alternative healer
- □ Podiatrist
- □ Other, please state: _____

8. This complaint is worse with:

□ Sitting □ Walking □ Standing □ Bending □ Lying □ Moving □ Working
□ Lifting □ Turning head □ Coughing/Sneezing/Pushing □ Not dependent on posture or movement
□ Other activity/posture, namely: _____

9. This complaint is better with:

□ Sitting □ Walking □ Standing □ Bending □ Lying
□ Movement □ Working □ Lifting □ Turning head □ Heat/Cold compress
□ Medicine □ Yoga □ Rest □ Sports □ Not dependent on posture or movement
□ Other activity/posture, namely: _____

10. How does the pain feel?

□ Nagging	□ Tingling	□ Shooting	□ Sharp	□ Burning
□ Deep	□ Superficial	□ Irritating	□ Numb	□ Tired/Stiff
□ Dull	□ Achy	□ Cramps	□ Throbbing	□ Stabbing

□ Other: _____

11. Does the pain travel?

□ Arm L / R before / now
□ Leg L / R before / now

12. Rate the pain:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (a lot of pain)

13. Presence of the complaint:

□ Constant/Whole day □ A few times per day □ Once a day □ Variable (1x per....)

14. When is the pain the worst?

□ Morning □ Afternoon □ Evening □ Night

15. Do you have other important complaints or remarks? _____

Medical history:

1. Have you ever had an accident (ex. Car accident, personal or sport injury, fall)? If yes, when: _____
_____
2. Have you ever broken anything? If yes, what and when: _____
_____
3. Have you ever been admitted to the hospital? If yes, when: _____
_____
4. Have you ever had an operation? If yes, on what and when: _____
_____
5. What medications do you take and why: _____
Vitamins/supplements: _____

6. Special Tests:

Date of your last tests	< 6 mo.	6-18 mo.	> 18 mo.	never
X-rays	□	□	□	□
Urine test	□	□	□	□
Blood test	□	□	□	□
Chiropractic examination	□	□	□	□
Heart examination	□	□	□	□
Examination by other specialists	□	□	□	□

Lifestyle:

1. How are your life habits:	a lot	normal	little	none
Appetite	□	□	□	□
Sugar intake	□	□	□	□
Coffee/caffeine, how many cups per day	□	□	□	□
Water, how many glasses per day	□	□	□	□
Alcohol, how many glasses per day	□	□	□	□
Smoking, how many per day	□	□	□	□
Drugs	□	□	□	□
Sleep	□	□	□	□
Stress level	□	□	□	□
Hobby/sporting activities: _____	□	□	□	□

2. How old is your mattress? _____ Is your mattress/pillow comfortable? □ yes □ no □ moderate

Do you sleep on your: □ Stomach □ Back □ Side □ Variable

3. Do you use:

□ Foot supports L / R □ Heel lifts L / R □ Other, namely: _____

4. Are you left or right handed: L / R

Patient Signature: _____ Date: _____