North Sea Chiropractic

Confidential Patient History

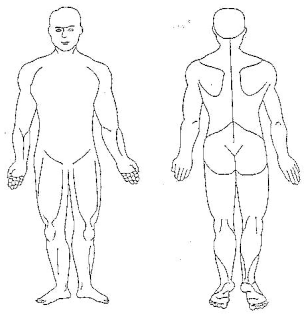
Please complete this questionnaire and bring it to your first appointment.

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: _____
State ID# (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: _____