REGISTRATION FORM

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Dear Madam, Sir,

Please read en think carefully about the following questions, answer them as well as you can.
During the consultation some of them can be explained further, but please try to give all details on this form.
Thank you for your effort.

Personal information

Last name: First name: m / f

Address:

Zip code: City:

Date of birth: example 23-4-1980 Place of birth:

Phone daytime: Phone other:

E-mail address:

Present occupation: Previous occupation:

Sport & hobby:

Family doctor: Phone:

Specialist: Phone:

Therapist: Phone:

Medicine use:

How did you hear about us?

Complaints

What is your main complaint?

When did it start and was there any special situation at that time?

When you have pain, is it stinging, burning, whining, blazing, throbbing, tightness, etc. ?

Is it regular, is it always or sometimes (when and how often)?

When is it better in certain conditions, e.g. when cold, hot, rested, stressed, hungry, eating, moving body position.

When is it worse?

In which mood are you generally, e.g. sad, anxious, restless, irritated, etc.?

Are there periods of breakdown during day of night?

Do you wake up at night, if so at what time?

How is your stool? times daily times a week
Consistency:
Color:

Do you like or don't you like: sour, sweet, spicy bitter or other tastes:

Which foods or drinks don't agree with you?

Do you have an urgent need of sweet bites? When?
Do you smoke? how much?
Do you drink coffee? how much?
Do you use alcoholic drinks? how much?
Do you use any drugs? Which and how much?

What are your secondary complaints at the moment?

Family hereditary disorders

Is there in your family any hereditary disorder, cardiac and vascular system disorder, rheumatism, cancer, diabetes, skin disorder, etc.:
Mother
Father
Other family

Personal case history

Please tick on this page which points apply to you complaints. Please tick the left column for complaints you had before, the right column for your complaints now. You can tick both columns when you had your present complaint also in the past. Please change as necessary at the possibilities *.

old recent

General

- headaches: *
- location in your head?
- sleeplessness
- difficulty to fall asleep
- change of weight: *
- dizziness
- fatigue: *
- double/blurred sight
- allergies

Bronchial tubes / throat, nose, ears

- breathless, gasping
- cough up phlegm
- chronic coughing
- asthma / bronchitis
- sore throat / inflammation
- sinusitis
- rustling / buzzing noise

Heart and vascular system

- blood pressure *
- swollen glands
- arteriosclerosis
- irregular heartbeat
- pain / tightness in chest
- palpitations
- cold hands / feet
- varicose veins
- liquid retention / oedema

Urinary system

- kidney infection / gravel / stones
- painful urination
- prostate problems
- bladder infection
- venereal disease
- unusual urine
- chanched libido

Women

- pregnant
- age of 1st menstruation
- painful menstruation
- irregular menstruation
- profuse menstruation
- painful breasts
- premenstrual syndrome
- vaginal discharge

old recent

Stomach / Ab domen

- infection of intestines
- constipation
- diarrhea
- dry mouth
- abdominal distention
- sickness, nausea
- flatulence
- abdominal *
- intestinal noise
- Hearthburn (gastic acid)
- bleedings

other:

Muscles / Joints

- muscles *
- lower back pain
- neck pain
- referred pain / radiation/ pins & needles
- pain in joints
- muscular *
- restricted movements
- rheumatism

Skin / Hair

- *
- frequent bruises
- *
- itching
- brittle nails
- *

Conditions of

- nervousness
- depressions
- extreme anxiety
- lack of concentration
- declining memory
- anxiousness
- extensive worrying
- listlessness
- suppressed emotions
- lack of self-confidence
- sorrow / sadness
- irresolution
- irritation
- hot flushes

other:

Please list in chronological order of age:

1. Diseases - operations - accidents - conditions, etc. with type of treatment, including minor occurrences like spraining, dental corrections, removing tonsils, eczema, etc. Everything can be very important!
2. Diseases that you suffered as a child.
3. How many times were you pregnant and describe the course of your pregnancies?
4. Important things or changes in your life (child or adult) such as loss of family member, divorce, nervous breakdown, periods of depression, etc.
5. Visiting other countries (outside of Europe).

Age	Disease / complaint / pregnancy / changes

Apart from the above statements, have you ever had any treatment by a physiotherapist, manual therapist, specialist doctor or by any alternative medical practitioner such as an homeopath, iriscopist, acupuncturist, magnetizer, etc.

Which illness was the most serious one in your life?

Which illness was the last one before your present complaints started?

Are your complaints worse with strong physical or psychological stress, climate changes, fever, menstruation, etc. When? :

Worse:

Once you have filled in the questionnaire, please save it to your desktop.
Then email the saved file to balie@imc-amsterdam.nl