

We would like to kindly ask you to fill out this form and hand it in on your first visit. All information will be classified and will only be used for your personal medical file at Chiropractie Leiden.
Thank you for your cooperation.

Personal data

Name _____ Initials _____

(for married women, please also your maiden name)

Address _____

Zipcode _____ Town/City _____

Home telephone number _____ Daytime telephone number _____

E-mail address _____

Date of birth _____ Occupation _____

Health Insurance Company _____ Contract number _____

(if we put this information in the system, it will appear on the Chiropractie Leiden payment receipts)

General Practioner _____ Town/City _____

Have you ever been treated for this complaint before? (name please) :

- | | |
|--|---|
| <input type="checkbox"/> G.P. | <input type="checkbox"/> foot therapist |
| <input type="checkbox"/> physical therapist | <input type="checkbox"/> manual therapist |
| <input type="checkbox"/> exercise therapist | <input type="checkbox"/> neurologist |
| <input type="checkbox"/> homeopathic doctor | <input type="checkbox"/> acupuncturist |
| <input type="checkbox"/> surgeon | <input type="checkbox"/> orthopedist |
| <input type="checkbox"/> alternative health provider | <input type="checkbox"/> other _____ |

Who referred you to our practice?

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> telephone directory | <input type="checkbox"/> phone book | <input type="checkbox"/> family member, friend, colleague |
| <input type="checkbox"/> information evening | <input type="checkbox"/> newspaper ad | <input type="checkbox"/> my G.P. |
| <input type="checkbox"/> internet | | <input type="checkbox"/> another therapist/doctor (name) _____ |

Would you like your chiropractor to send your g.p. or therapist a report of findings, description of your treatment and progress at Chiropractie Leiden? (It is complimentary and free of charge).

- Yes. Please send it to: _____
- No thanks.

When did your present complaints first manifest?

Check your main complaints. When did they first manifest themselves?

General

- Allergies
- Seizures
- Numbness
- Dizziness
- Fainting
- Headaches
- Nerve pain

Skin

- Dry skin
- Skin irritation
- Varicose veins
- Bruises

Other

- Emphysema
- Thyroiditis
- Gout
- Ulcer
- Cancer
- Heart problems
- Miscarriages
- Bronchitis
- Tuberculosis
- Diabetes
- Excema
- Arthritis

- Multiple Sclerosis
- Polio
- Stroke
- Alcoholism
- Anemia
- Appendicitis
- Rachiatis

Stomach and Viscera

- Colon problems
- Constipation
- Stomach pain
- Diarrhea
- Difficult digestion
- Gallbladder problems
- Liver problems
- Hemorrhoids

Muscles and Joints

- Inflammation of joints
- Mucus fair inflammation
- Foot problems
- Lumbar pain
- Pain or stiffness in neck
- Pain in between shoulder blades
- Sciatica
- Herniated disc

Urinary Tract

- Enuresis
- Blood in urine
- Excessive urination
- Kidney stones
- Inflammation of kidneys
- Prostate problems
- Painful urination
- Poor bladder control

Heart and Blood Vessels

- High blood pressure
- Low blood pressure
- Pain in heart area
- Poor circulation
- Rapid pulse
- Slow pulse
- Swelling of ankles

Respiratory Tract

- Pain in the chest
- Chronic coughing
- Difficulty breathing
- Blood coughing
- Coughing of mucus
- Wheezing or panting

Eyes, ears, nose and throat

- Asthma

- Cold
- Deafness
- Ear pain
- Eye pain
- Stuffy nose
- Nose bleeds
- Nasal inflammation

Pain and numbness in

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet

For female patients

- Inflammation of breasts
- Cramps/pain in the back
- Painful menstruation
- Excessive menstruation
- Menopausal problems
- Irregular menstruation
- Nodules in breast(s)
- Excessive vaginal discharge

Surgeries

Type/date: _____

Accidents

Type/date: _____

Do you take medicine?

Name/what for: _____

Exams	Never	Date	Where
Urine test	<input type="checkbox"/>	_____	_____
X-ray/MRI/Scan	<input type="checkbox"/>	_____	_____
Blood test	<input type="checkbox"/>	_____	_____
Chiropractic examination	<input type="checkbox"/>	_____	_____
Heart exam	<input type="checkbox"/>	_____	_____

Routines	a lot	normal	little	none
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking (per day)	_____			

Do you use: Orthotic supports Heel raise Other _____