Kiropraktik

Please fill in this form at the first consultation and answer it as well as you can. The answers are very important to us in order to give you the best treatment possible. If you are in doubt then skip the question. We will review the form at the consultation.

Name:_____ **Date:**_____

CPR:_____

Phone number:_____ **E-mail address:**_____

What is the reason for your consultation? If in pain, please write where and mark it on the figure.

_____

_____

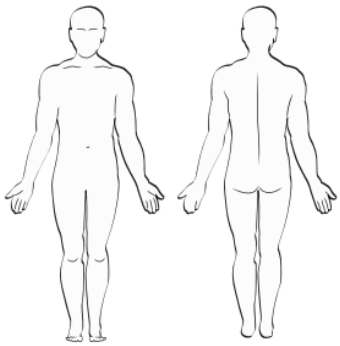
_____

_____

_____

_____

_____



When did the symptoms start?

Approx. date: _____

How did the symptoms start?

☐ Slowly, increasing.

☐ Suddenly

What triggered the symptoms?

☐ No known reason/ cause

☐ Other – please note what:_____

Are there any differences in the symptoms throughout the day?

☐ Worst in the morning

☐ Worst in the morning and evening

☐ Increases during the day

☐ No pattern

What triggers your symptoms?_____

What eases your symptoms? _____

Pain intensity (please mark an X over the number, which describes your pain best)
At this moment

No Pain — Worst pain imaginable

0	1	2	3	4	5	6	7	8	9	10

Are the symptoms: ☐ Decreasing ☐ Unchanged ☐ Increasing

Current medicine (e.g. pain-reliever, doctor prescribed medicine, birth-control pills)?
Name. Please mark effect of pain-reliever.

1._____ _____ _____ ☐ None ☐ Medium ☐ Good
2._____ _____ _____ ☐ None ☐ Medium ☐ Good
3._____ _____ _____ ☐ None ☐ Medium ☐ Good
4._____ _____ _____ ☐ None ☐ Medium ☐ Good
5._____ _____ _____ ☐ None ☐ Medium ☐ Good

Have you ever experienced the same or similar symptoms?

☐ No

☐ Yes – how frequent?_____

Have you been examined elsewhere (E.g. doctor, hospital, MR-scanning, X-ray)?

☐ No

☐ Yes – when and where?_____

Do you approve that the chiropractor, if necessary, collects your medical records, x-rays etc.?

☐ Yes ☐ No

Have you received any other treatment for your current symptoms?

☐ No

☐ Yes – what kind and effect? _____

_____

Does anybody else in your family have problems relating to the same area?

☐ No

☐ Yes – what problems (if you know)?_____

Have you been/ are you on sick leave due to your current symptoms?

☐ No

☐ Yes – how long? _____

Do you suffer from other diseases (E.g. cancer, rheumatism, brittle-bone disease)?

☐ No

☐ Yes – which one(s)?_____

Have you ever had surgery?

☐ No

☐ Yes – when and for what? _____

Do you smoke?

☐ No

☐ Yes – how much?_____

Do you normally exercise?

☐ No

☐ Yes – how and how often?_____

What is/ was your occupation?_____

Which chiropractor have you been recommended to?

☐ Grethe Thøstesen ☐ Mathilde Christensen

☐ John Sandsberg ☐ Thomas Damsgaard

How did you hear about the clinic?

☐ Doctor ☐ Physiotherapist ☐ Reflexologist ☐ Krak ☐ Masseur

☐ Family ☐ Friend ☐ College ☐ Google ☐ Facebook

Name (if possible):_____

Do you or does anyone in your nearest family have any inheritable diseases?

☐ No

☐ Yes – which one(s)? _____

Do you have a health insurance (membership of "Denmark" does not count)?

☐ No

☐ Yes – which one?_____

Is there anything else that the chiropractor should know?_____

_____

Do you approve correspondence/ exchange of information with other specialists (usually general practitioner)?

☐ No ☐ Yes

Do you wish to receive newsletters for the Chiropractic guide?

☐ No ☐ Yes – to which e-mail? _____

When the form is complete please return it to the secretary. Thank you.