# 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.**

_____

_____

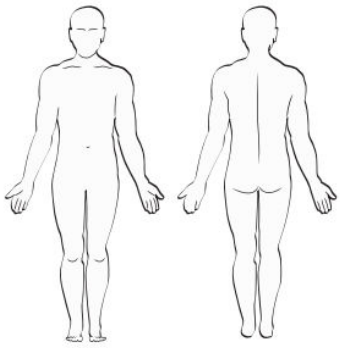
_____

_____

_____

_____

_____



**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.