

Questionnaire

Date first visit: ... / ... / 20...

patient no.:

Surname: Street:
 Initials / first name: Postal code:
 Date of birth: / / Place:
 Married: yes / no Telephone: (home)
 Children: yes / no; number: (work)
 E-mail:
 Profession: Would you like info through e-mail?: yes / no
 Leisure:
 GP name: Heart about us through:
 GP address: Referred by GP / physioth. / or:

Please describe your complaints:

When did these complaints start? Date: ... / ... /

What is the cause of your complaints?

Did you experience these complaints before? yes / no

Location of complaints? Please indicate on picture at the back ►►►► **S.O.S.**

Does the pain radiate (eg. to arm or leg)? yes / no:

What aggravates the pain (eg. sitting, standing)?

What reduces the pain?

Have you been treated for this before? yes / no ; by:

Have you been or are you treated for this in the hospital? yes / no :

Specialism:

Tests: X-ray / MRI / CT / EMG / Blood / Urine / or:

Do you have complaints in other areas, muscles or joints? yes / no:

Have you ever experienced one of the following? Dizziness / Fainting / Tinnitus / Ear pain / Pain sinuses / Jaw pain / Headache / Migraine / Facial pain / Sleeplessness / Tiredness / Depression / Palpitations of the heart / or:

Do you have a cardiovascular disease? yes / no:

Do you have respiratory complaints? yes / no:

Do you have gastro-intestinal problems? yes / no:

Do you have kidney/urinary tract problems? yes / no:

Do you have gynaecological complaints? yes / no:

Do or did you have any of the following? Osteoporosis / Rheumatoid arthritis / Blood disease / Allergy / Hereditary disease / Diabetes / Cancer / MS / Epilepsy /

Did you ever experience the following? Serious fall / Misstep while walking / Accident

Did you ever experience a fracture? yes / no:

Have you ever been operated or hospitalized? yes / no:

Do you use medicines? yes / no:

Do you suffer from side effects?

yes / no:

What are your daily habits regarding:

Alcohol use: > 3 glasses / 1-3 glasses / none
 Smoking: > 5 cigarettes / 1-5 cigarettes / none
 Physical exercise: much (couple of hours per week) / little (once a week) / none
 Sleeping: >8 hours / 7-8 hours / < 7 hours
 Coffee: > 4 cups / 1-4 cups / none

Do you give us permission to send a routine evaluation to your treating physician (eg. GP)

yes / no:

Please indicate the type and location of your present complaints in the below picture by using the below symbols:

- Dull: VVVVV
- Burning: XXXXX
- Stiff: IIIIIIIII
- Tingling: 000000
- Cramping: ~~~~~
- Stabbing: ↓↓↓↓↓
- Other:

