DATE 1st CONSULTATION: ……

Personal Information:

Name: … Surname: … Date of Birth: …

Full name mother or father: …

Address: … Postal Code: … Town: …

Tel.private: … Tel.mobile: …

E-mail address: …
Hobby/sport: …

GP (incl address): ... Insurance company + registration nr.: …

Date last visit GP and reason why:…

Present Length: … Weight: …

Brothers/Sisters: ….Sisther(s) …Brother(s)

How did you find out about our practice? Name referral: internet/walk by

What is the reason of your visit to this practice? (Preventive or a specific complaint)

What is the reason for your visit to the practice:…….

Medicine or treatment undergoing for this complaint: ….

Have you ever been to a chiropractor before? …..

If yes: When: … How regular?: … Chiropractor name: ….

Starting date of complaint: …… Complaint began: insidious / over time / through specific incident

Duration of the complaint: …… minutes / hours / days / months / years

Pattern of complaint: constant / cyclisch / sometimes / onregelmatig / unregular / once of

What causes the complaint:….

What makes it worse: ….

What makes it better: ….

The Delivery:

Was the delivery abnormal?(ceserian, vacuumpump, pliers, long durated, painstillers/anaesthetic etc)
Describe:……

Delivery at home or at hospital:..

Medicine used during pregnancy: …

The first years:
Did your child crawl before walking? …….

Did your child receive any vaccinations? If YES, which? …..

Did your child have bad reactions after any vaccinations? .....

Childhood illness? …..

Did your child receive any medications (Antibiotics or inhaler) for an extended period of time? ….

Other medicines or vitamins: …

Did your child receive any operations?….

Did your child ever fell or jumped from a hight higher than 1 meter? Explain:

Psychological trauma or stressfull situations/periods: …

Was your child involved in a automobile accident? …

My child eat: super healthy(no clourants- and artificial sweetners) / heallthy / relatively healthy / not so healthy / unhealthy

Does your child complain or have any problems with:

Headaches	yes/no	Migraine	yes/no
Dizzyness	yes/no	Tinnitus	yes/no
Sinusproblems	yes/no	Bronchitis	yes/no
Throath infection	yes/no	Ear infection	yes/no
Breathing/Tonsils	yes/no	Stiff neck	yes/no
Backpain	yes/no	Neckpain	yes/no
Pins and nodles in arms or legs	yes/no	Cold hands or feet	yes/no
Eczema	yes/no	Allergies	yes/no
Heartproblems	yes/no	Digestive problems	yes/no
Constipation or diarhea:	yes/no	Cramps	yes/no
Bladder infection:	yes/no	Hormonal problems	yes/no
Fainting	yes/no	Fever	yes/no
Sleepingproblems:	yes/no	Concentration problems	yes/no
Nervous	yes/no	Panic attacks:	yes/no
Depressed	yes/no		

Other: …

Thank you very much for answering the above questions!

ACS
ADVANCED CHIROPRACTIC STUDIO