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Questionnaire Osteopathy

Dear sir, madam,

Please read the following questions thoroughly and answer them as much as possible. These questions will be discussed in the first consult. Thank you for you cooperation.

Surname:_______________________________First name:___________________

Address:________________________________Postal code:__________________

City:________________________date of birth:__________________M/F

Telephone number:__________________E-mail address:_____________________

Profession:____

Sports, Hobby's:____

Medicine/drug use:____

Family physician:_________________________Tel.nr:______________________

What is your current complaint?____

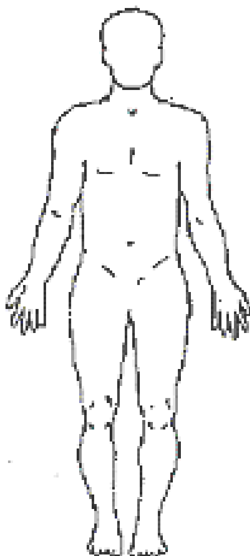
____

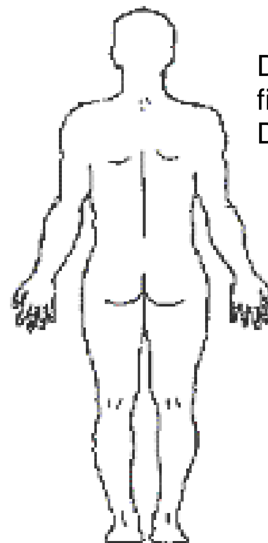
When did it start and under what circumstances?____________________________

____

Do you see a pattern in your complaint?___________________________________

____





Draw your complaint on the figures.
Draw scars in red.

What circumstances improve your complaint? (For example: warmth, cold, rest, movement, eating, certain posture, physical or mental state, relaxation) ______________________
____

What circumstances worsen your complaint?___________________________________

How is the bowel/stool function? (Regular/not regular/frequency)__________________

____

Do you wake up at night? If yes, why and at what time?__________________________

____

Do you prefer certain food and spices (Fro example: sweet, sauer, spicy, bitter?______

____

What food or spices don't you like or have difficulty in digesting?__________________
____

____

Do you smoke? How much?____

Do you drink alcohol? How much?____

Do you drink coffee? How much?____

Are there any other complaints?

____

____

____

Hereditary diseases and illnesses: (heart- and vascular problems, rheumatics, diabetes, etc.) and non-hereditary diseases.

Mother:____

Father:____

Other family members:____

____

Health and disease history:

Could you, in chronological order, describe:
-What diseases, operations, accidents and treatments you have had in your life.
 Think also of complaints like eczema, allergies, small accidents like twists and small operations.
- Pregnancies and how they went.
- Important things that have happened in life that could influence you life. (For instance separation, mental depressions, etc.)
- Vacations abroad. (tropical areas, etc.)

Age ____disease / complaint/ pregnancy / development____________________

________ - ____

________ - ____

________ - ____

________ - ____

________ - ____

________ - ____

________ - ____

________ - ____

________ - ____

________ - ____

________ - ____

________ - ____

________ - ____

What disease was the most difficult in life?________________________________

____

What disease, accident, operation was the last before the current complaint started?

____

Have you been treated for the current complaint before? If so, what kind of treatment was that?

____

Please accent the following questions,
The left column is for past situations, the right for the recent situation.

GENERAL

0 0 headaches: daily/weekly/monthly
where in the head?________________
0 0 sleeplessness
0 0 change in weight: more/less
0 0 dizziness
0 0 fatigue: continuous/morning/afternoon/night
0 0 allergy
0 0 swollen glands

AIRWAY

0 0 chronically cough
0 0 chronically cold
0 0 asthma
0 0 throat pain/inflammations
0 0 sinusitis
0 0 thinitis

HEART AND BLOODVESSELS

0 0 high/low blood pressure
0 0 arthrosclerosis
0 0 pain on the chest
0 0 palpitation of the heart
0 0 cold hands/feet
0 0 varicose vein
0 0 holding fluids

URINETRACT

0 0 kidney infection/stones
0 0 pain during urinating
0 0 prostate problems
0 0 blather infection
0 0 changing in urine

WOMAN

Pregnant Yes/No
Children Yes/No:___
Age first menstruation:____
0 0 painful menstruation
0 0 irregular menstruation
0 0 lasting menstruation
0 0 premenstrual syndrome

STOMACH/ INTESTINES

0 0 bowel inflammation
0 0 constipation
0 0 diarrhoea
0 0 swollen abdomen
0 0 nausea
0 0 cramps
0 0 bowel pain
0 0 stomach acid
0 0 blood in stool
0 0 other:_______________

MUSCLES / JOINTS

0 0 tenseness/weak muscles
0 0 low back pain
0 0 neck pain
0 0 tingling/numbness
0 0 joint pain
0 0 muscle pain/cramps
0 0 problems with moving

SKIN

0 0 eczema/rashes
0 0 fast bruising
0 0 dry skin/sweating
0 0 itching

MENTAL STATE

0 0 nervous
0 0 depression
0 0 concentration weakness
0 0 anxiety
0 0 worrying
0 0 irresolute
0 0 irritated

0 0 other:_______________

____