

**Intake sheet adults**

Please fill in the questions below as clearly and accurately as possible. They will be discussed during the intake interview. All your details are treated with confidentiality and remain private.

**Personal data:**

Name: First Name: Man / Woman:

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Address:

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Postal Code: City:

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Date Of Birth: Place Of Birth:

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Phone Number: Cell Phone Number:

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Email Address:

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Current Job: Earlier Job:

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Sports/ Hobbies:

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GP Practice: City/Place:

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|  | Yes, I give permission to inform my doctor if needed. |

Medicines/Reason:

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Where did you hear from us?

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Specialist current/earlier:

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Location/Hospital: City/Place:

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**Complaints**

What is your main complaint?

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When and under which circumstances did it start?

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If you are in pain, can you describe it? (stinging/burning/piercing/nagging/pounding)

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Are there patterns in how and when your pains occur? (morning/midday/evening/night)

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What reduces your pain? (cold, warmth, rest, position, hunger, eating, movement)

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What aggravates your pain worse? (intense physical/ psychological stress, climate change, fever, menstruation)

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How are you feeling in general? (sad, fearful, restless, irritated)

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What are the additional complaints at this moment?

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How is your bowel movement?

X times a day X times a week;

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| --- | --- | --- | --- |
|  | Regularly |  | Irregular |

Consistency:

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| --- | --- | --- | --- |
|  | Mushy |  | Hard |
|  | Solid |  | Watery |
|  | Soft |  | a/t (non applicable) |

Colour:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Dark brown |  | Yellow-brown |
|  | Light brown |  | White |
|  | Black |  | a/t (non applicable) |

Which food or drinks are not good for you?

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Do you crave sweets?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Do you smoke?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

… Cigarettes a day / week

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Do you drink coffee?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

… cups a day / week

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Do you drink alcohol?

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|  | Yes |  | No |

… glasses a day / week

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Do you use drugs?

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| --- | --- | --- | --- |
|  | Yes |  | No |

Which one(s) and how often:

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Have you ever been treated by a physiotherapist, manual therapist, chiropractor or an alternative healer (eg homeopath, mesologist, acupuncturist)? For which complaints?

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Which illness was the worst in your life so far?

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Which illness, accident, operation was the last one before your current complaints?

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**History of diseases**

If applicable, please fill in your age when you were suffering from the following symptoms:

**General**

|  |  |  |  |
| --- | --- | --- | --- |
|  | headache |  | dizziness |
|  | troubles falling asleep |  | Fatigue |
|  | bad/interrupted sleep |  | double / blurred / poor vision |
|  | significant weight change |  | allergy: |

**Stomach / intestines**

|  |  |  |  |
| --- | --- | --- | --- |
|  | intestinal inflammation |  | constipation |
|  | diarrhea |  | dry mouth |
|  | abdominal distension |  | Nausea |
|  | flatulence |  | abdominal pain/cramps |
|  | bubbling belly |  | heartburn |
|  | remaining: |  |  |

**Respiratory system / ENT**

|  |  |  |  |
| --- | --- | --- | --- |
|  | shortness of breath |  | chronic cough |
|  | asthma |  | sore throat / inflammation |
|  | sinusitis (inflamed forehead cavity) |  | Ear ringing |

**Heart and blood vessels**

|  |  |  |  |
| --- | --- | --- | --- |
|  | high/low blood pressure |  | irregular heartbeat |
|  | arteriosclerosis |  | palpitations |
|  | cold hands/feet |  | varicose veins |
|  | fluid retention |  |  |

**Muscles/ Joints**

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| --- | --- | --- | --- |
|  | tense muscles |  | weak muscles |
|  | lower back pain |  | neck pain |
|  | tingling: |  | joint pains: |
|  | muscle aches/cramps |  | movement restriction: |
|  | rheumatism (diagnosed by doctor?) |  |  |

**Urinary tract**

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| --- | --- | --- | --- |
|  | kidney infection/stones |  | having pain when peeing |
|  | prostate complaints |  | cystitis |
|  | venereal disease |  | change of urine |
|  | change of libido |  |  |

**Skin**

|  |  |  |  |
| --- | --- | --- | --- |
|  | eczema |  | quick bruising |
|  | dry skin |  | excessive perspiration |
|  | itching |  | hair loss |

**Vrouw**

|  |  |  |  |
| --- | --- | --- | --- |
|  | pregnant YES / NO |  | painful periods |
|  | irregular menstruation |  | sore breasts |
|  | premenstrual syndrome |  | leucorrhea (white vaginal discharge) |
|  | hot flashes |  | menopause |

**Condition**

|  |  |  |  |
| --- | --- | --- | --- |
|  | nervous |  | depression |
|  | irritability |  | concentration weakness |
|  | memory reduction |  | fear |
|  | worry |  | suppressed emotions |
|  | sadness |  |  |

**Please write down chronologically all: complaints/pains, illnesses, operations, accidents and treatments you have experienced in your life. Also small things like fractures, sprains, dental treatments, braces, tonsils, eczema, allergies. Please write down your age at that time as well.**

**Don’t forget your experienced childhood diseases and the course of possible pregnancies (completed / not completed).**

**Important or intense periods in your life can be important (divorce, death, depression, and stress). Also visits abroad.**

Age History of diseases

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Thank you for your time and effort!

Team Osteopathy Verstraten

[Treatment agreement](https://osteopathieverstraten.nl/en/treatment-agreement/)

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