Vitel Osteopathie
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Date: _____

Please study and answer the following questions as accurately as possible. The details will be discussed with you during the initial consultation. Naturally the details will be kept strictly private. Thank you for your kind attention.

Surname: _____ First name: _____ Mr/Mrs

Address: _____ Post code: _____

Town: _____ Date of birth: _____

Birthplace: _____ Tel.: _____

Insurance company: _____ National Insurance Number: _____

Email address: _____ Do you want to receive the newsletter? ❑ Yes ❑ No

Occupation: _____ Previous occupations: _____

Sport, Hobby, Leisure: _____

Medicines taken: _____

Doctor: _____ spec: _____

Address: _____ Tel: _____

Post code: _____ Town: _____

❑ I do not wish a report to be sent to my doctor* _____

Who informed / advised you? _____

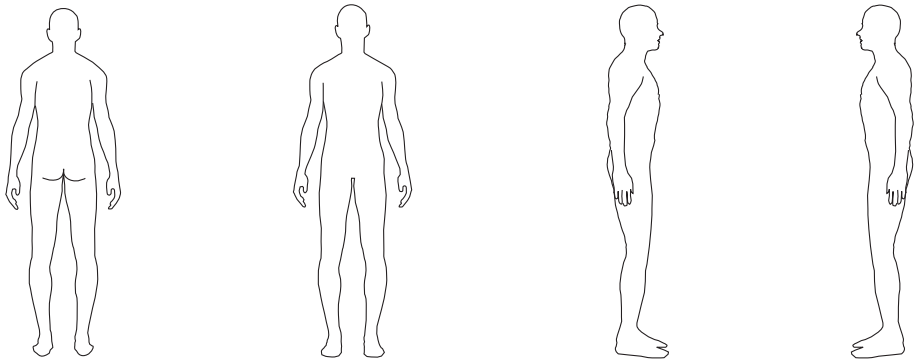
What is your main complaint? _____

_____

When did it begin and under which circumstances? _____

_____

Please indicate on the figure where you feel the complaint? Please indicate in red where you have scar tissue?
* See intake form (tick).



If you are in pain, can you describe the pain?
(stabbing, burning, nagging, shooting, throbbing, tightening):

_____

Is there a regularity or pattern to your complaint? _____

Which circumstances give relief? (e.g. cold, warmth, rest, stress, hunger, eating, posture, movement):

_____

And worsening? _____

How do you feel in general? (sad, anxious, restless, irritated):

_____

Are there moments of breakdown during the day? _____

Do you wake up during the night, what time? _____

How are your bowel movements?_____ x daily/ _____x weekly. Regular / irregular
Consistency: firm/ pulp/ soft/ watery* Colour: white/ lightbrown/ yellowbrown/ darkbrown/ black*

Do you have a preference or dislike for sourness, sweetness, sharpness, bitterness?

prefer: _____dislike: _____

Which food and/or drinks don't agree with you? _____

Do you crave for sweetness? YES/NO _____

Do you smoke? How much? _____

Do you drink alcohol? How much? _____

Do you use drugs? Which and how often? Do you drink coffee? How much? _____
_____

Which are the accompanying complaints now?

1. _____

2. _____

3. _____

Family illnesses: inherited diseases (heart and arterial, reumatic, cancer, diabetes, skin complaints,
etc.) and diseases not inherited

Mother: _____

Father: _____

Other family members: _____
_

Please tick the points on this page that apply to you. The column on the left is for old complaints and on the right for recent complaints. If your current complaint was also experienced previously, tick both columns. Cross out what does not apply when choices are marked with an asterisk (*)

GENERAL

- ❑ ❑ headache: daily/ weekly/ monthly *
- ❑ ❑ Where in your head?_____
- ❑ ❑ sleeplessness
- ❑ ❑ difficulty falling asleep
- ❑ ❑ weight change: increase / decrease *
- ❑ ❑ dizziness
- ❑ ❑ tiredness: continuously/ morning/ midday/ evening *
- ❑ ❑ double/ blurred vision *
- ❑ ❑ allergy: _____
- ❑ ❑ other: _____

AIRWAYS/EARS NOSE THROAT.

- ❑ ❑
- ❑ ❑ breathing difficulty
- ❑ ❑ chronic cough
- ❑ ❑ chronic cold
- ❑ ❑ asthma
- ❑ ❑ sore throat/ throat infection
- ❑ ❑ sinusitis
- ❑ ❑ tinnitis
- ❑ ❑ pneumonia
- ❑ ❑ other _____

HEART & ARTERIES

- ❑ ❑ high/ low blood pressure*
- ❑ ❑ swollen glands
- ❑ ❑ hardening of the arteries
- ❑ ❑ arrhythmic heartbeat
- ❑ ❑ pain/ tightening in chest
- ❑ ❑ heart palpitation
- ❑ ❑ cold hands/ feet
- ❑ ❑ varicose veins
- ❑ ❑ moisture retention
- ❑ ❑ other _____

URINARY TRACT

- ❑ ❑ kidney infection/ stones *
- ❑ ❑ pain when urinating
- ❑ ❑ prostate problems
- ❑ ❑ bladder infection
- ❑ ❑ sexual diseases
- ❑ ❑ change in appearance of urine
- ❑ ❑ change in libido
- ❑ ❑ other _____

SKIN

- ❑ ❑ eczema/ rash *
- ❑ ❑ bruise easily
- ❑ ❑ dry skin/ perspiration *
- ❑ ❑ itching
- ❑ ❑ nails break easily
- ❑ ❑ hair loss/ fragile hair *
- ❑ ❑ other _____

STOMACH/ INTESTINES

- ❑ ❑ intestinal infection
- ❑ ❑ constipation
- ❑ ❑ diarrhoea
- ❑ ❑ dry mouth
- ❑ ❑ swollen stomach
- ❑ ❑ nausea
- ❑ ❑ flatulence
- ❑ ❑ stomach ache/ cramp*
- ❑ ❑ indigestion
- ❑ ❑ bleeding
- ❑ ❑ other:_____

MUSCLES/ JOINTS

- ❑ ❑ tense / limp muscles *
- ❑ ❑ lower-back pain
- ❑ ❑ neck pain
- ❑ ❑ tingling/ radiating pain
- ❑ ❑ joint pain
- ❑ ❑ muscle pain / cramp
- ❑ ❑ restricted movement
- ❑ ❑ rheuma
- ❑ ❑ other:_____

FEMALE Pregnant YES/NO

Age at first menstruation:_____

- ❑ ❑ painful menstruation
- ❑ ❑ irregular menstruation
- ❑ ❑ lengthy menstruation
- ❑ ❑ painful breasts
- ❑ ❑ premenstrual syndrome
- ❑ ❑ white discharge
- ❑ ❑ other:_____

DISPOSITION

- ❑ ❑ nervousness
- ❑ ❑ depression
- ❑ ❑ anxiety
- ❑ ❑ concentration loss
- ❑ ❑ memory difficulties
- ❑ ❑ fear
- ❑ ❑ excessive worrying
- ❑ ❑ listlessness
- ❑ ❑ bottle things up
- ❑ ❑ lack of confidence
- ❑ ❑ sorrow, sadness
- ❑ ❑ indecision
- ❑ ❑ easily irritated
- ❑ ❑ hot flushes
- ❑ ❑ other: _____

_____

ILLNESS RECORD.

Please state as chronologically as possible:

1. Which illnesses, operations, accidents and treatments you have had in your life. Also apparently trivial things such as sprains, dental treatment, tonsils removal, and eczema can be important.
2. Children's illnesses you have had and any vaccinations.
3. Any pregnancies and how they developed.
4. Important developments in your life can be equally of influence (divorce, nervous breakdown, depression, etc.).
5. Overseas visits (outside Europe) and any vaccinations.

AGE ILLNESS/ COMPLAINT/ PREGNANCY/ DEVELOPMENT.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Apart from any of the above information, have you ever been treated by a physiotherapist, manual therapist, specialist or alternative therapist (e.g. homeopathist, iriscopist, acupuncturist, magneto therapist).

_____

_____

Which was the most serious illness in your life? _____

Which illness, accident, operation, was the last to occur before the start of your current complaint?

_____

Was the current complaint worsened by heavy physical or mental exertion, climate change, fever, menstruation, etc?
When: _____

_____

Worsening from:_____