

## New patient intake form:

Name: Klik of tik om tekst in te voeren.

Address: Klik of tik om tekst in te voeren.

Principle phone number: Klik of tik om tekst in te voeren.

Date of Birth: Klik of tik om een datum in te voeren.

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### 1. What is your main complaint?

Kies of tik om tekst in te voeren.

Other complaints: Klik of tik om tekst in te voeren.

How long have you had this problem? Klik of tik om tekst in te voeren.

What makes your symptoms improve? Klik of tik om tekst in te voeren.

What makes your symptoms worse? Klik of tik om tekst in te voeren.

### 2. Western medical diagnosis:

Klik of tik om tekst in te voeren.

### 3. List of medication:

This also includes over the counter medication such as painkillers, birth control pill, herbal or vitamin supplements, etc.

Klik of tik om tekst in te voeren.

### 4. Your medical history:

Surgeries, accidents, major events (car accidents, significant trauma's)? Please list in chronological order

Childhood illnesses (0-12 years): Klik of tik om tekst in te voeren.

Adolescence illnesses (13-25 years): Klik of tik om tekst in te voeren.

Adult illnesses (26-55 years): Klik of tik om tekst in te voeren.

Elderly illnesses (56 years and up): Klik of tik om tekst in te voeren.



**5. Family medical history:**

Please note all major illnesses in your immediate family (children, parents, grandparents), e.g. diabetes, heart disease, hypertension, neurological, allergies, psychological, or orthopedic disorders, etc.

Klik of tik om tekst in te voeren.

**6. Personal and social history:**

Please list your daily routine such as sports performance, training, sleep and dietary patterns, preference for certain foods, intake of leisure drugs or alcohol etc.

Kies een item.