Please answer the questions as well as you can. If you are in doubt leave it blank and move on to the next question. We will go through the questionnaire in the consultation.

Name: _____ **Date:** _____/_____/_____

1. Do you have health insurance? Yes____, which:_____ No_____

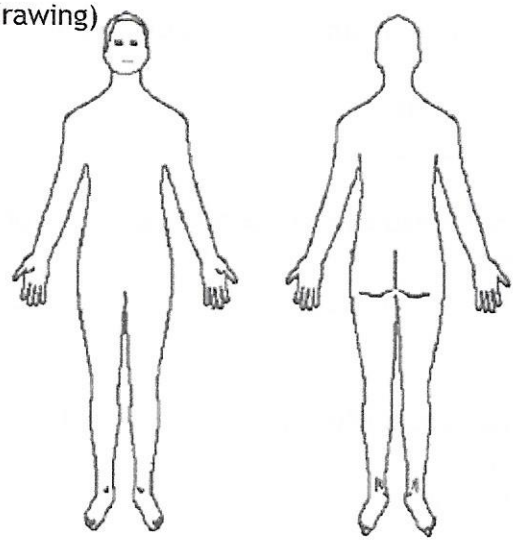
2. Email:_____

3. Where do you have pain/symptoms? (write on lines **AND** mark on drawing)

_____

_____

_____



4. When did the symptoms begin?

_____

5. How did it start?

Suddenly: ____

Slowly, over time: ____

6. What caused it?

No known cause :____

Other:_____

_____

7. Is there difference in the symptoms during the day?

- Worse morning: ____
- Worse morning and evening: ____
- Gets worse during the day: ____
- Worse at night and trouble sleeping: ____
- No pattern: ____

8. Pain intensity: (Mark with an **X** on the line)

Right now:

no pain — most pain

0 _____ **100**

Within the last week:

no pain — most pain

0 _____ **100**

9. Actual medication (all of it):

Name:	Effect: None	Middle	Good
1_____	_____	_____	_____
2_____	_____	_____	_____
3_____	_____	_____	_____

10. How would you characterize the pain/symptoms (stabbing, deep, superficial, constant, dull, aching):

_____

_____

11. Are there positions, movements and/or activities that make the symptoms worse?

_____

_____

Turn over

12. Are there positions, movements and/or activities that make the symptoms better?

_____

_____

13. Have you experienced these symptoms before?

No: ____

Yes - When and how often? _____

14. Have you had any previous accidents or traumas of any kind?

No ____

Yes - what? _____

_____

15. Have you been treated elsewhere for your actual symptoms

No ____

Yes - what? _____

_____

16. Are you suffering/have suffered from any other medical conditions?

No ____

Yes - what? _____

_____

17. Have you ever been in surgery?

No ____

Yes - when and for what? _____

_____

18. Do you smoke? No____ Yes - how much? _____

19. What is your job? _____

21. Have you been taking sick-days because of these symptoms?

No ____

Yes - for how long? _____

22. Do you workout on a weekly basis (sports, gym, fitness, running, biking etc)?

Nej ____

Yes - what and how often? _____

23. Who recommended you here?

Doctor____ Colleague____ Family____ Friend____ Other_____

THANK YOU FOR YOUR HELP. PLEASE TURN THE QUESTIONNAIRE OVER TO THE RECEPTIONIST.
THE CHIROPRACTOR WILL COME AND GET YOU SOON.