

REGISTRATION FORM



Address

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Dear Madam, Sir,

Please read and think carefully about the following questions and answer them as best as possible. During the consultation, some of them can be explained further, but please try to provide as much detail as you can on this form. Thank you for your effort and consideration.

Personal information

Last name:	First name:	M /F:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address:		
<input type="text"/>		
Zip code:	City:	
<input type="text"/>	<input type="text"/>	
Date of birth:	Place of birth:	
<input type="text"/> example 23-4-1980	<input type="text"/>	
Phone daytime:	E-mail address:	
<input type="text"/>	<input type="text"/>	
Sport & hobby:		
<input type="text"/>		
Present occupation:	Previous occupation:	
<input type="text"/>	<input type="text"/>	
Regular diagnosis:		
<input type="text"/>		
Family doctor:	Phone:	
<input type="text"/>	<input type="text"/>	
Specialist:	Phone:	
<input type="text"/>	<input type="text"/>	
Therapist:	Phone:	
<input type="text"/>	<input type="text"/>	
Medicine use:		
<input type="text"/>		
How did you hear about us?		
<input type="text"/>		

Symptoms

What is your main complaint?

When did it start and was there any special situation at that time?

When you have pain, is it stinging, burning, whining, blazing, throbbing, tightness, etc. ?

Is it regular, is it always or sometimes (when and how often)?

Does it get better under certain conditions, (e.g. when cold, hot, rested, stressed, hungry, eating, ...).

When does it get worse?

In which mood are you generally, e.g. sad, anxious, restless, irritated, etc.?

Are there periods of breakdown during day or night?

Do you wake up at night (if so at what time)?

How is your stool? times daily times a week

Consistency:

Color:

Do you like or don't like: sour, sweet, spicy bitter or other tastes:

Which foods or drinks don't agree with you?

Do you have an urgent need of sweet bites? When?

Do you smoke? how much?

Do you drink coffee? how much?

Do you use alcoholic drinks? how much?

Do you use any drugs? Which and how much?

What are your secondary complaints at the moment?

Family hereditary disorders

Are there any hereditary disorders in your family? Cardiac and vascular system disorder, rheumatism, cancer, diabetes, skin disorder, etc.:

Mother

Father

Other family

Personal case history

On this page, mark the symptoms that apply to you. Mark the left column “old” for symptoms/complaints you have previously experienced. Mark the right column “recent” for complaints/symptoms you are currently experiencing. Mark both columns if you have experienced your present symptoms in the past.

*At positions marked with * please provide additional details.*

old	recent		old	recent	
		General			Stomach / Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	headaches:	<input type="checkbox"/>	<input type="checkbox"/>	infection of intestines
		location in your head?	<input type="checkbox"/>	<input type="checkbox"/>	constipation
<input type="checkbox"/>	<input type="checkbox"/>	sleeplessness	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	difficulty to fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	dry mouth
<input type="checkbox"/>	<input type="checkbox"/>	change of weight:	<input type="checkbox"/>	<input type="checkbox"/>	abdominal distention
<input type="checkbox"/>	<input type="checkbox"/>	dizziness	<input type="checkbox"/>	<input type="checkbox"/>	sickness, nausea
<input type="checkbox"/>	<input type="checkbox"/>	fatigue:	<input type="checkbox"/>	<input type="checkbox"/>	flatulence
<input type="checkbox"/>	<input type="checkbox"/>	double/blurred sight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> abdominal *
<input type="checkbox"/>	<input type="checkbox"/>	allergies	<input type="checkbox"/>	<input type="checkbox"/>	intestinal noise
		Bronchial tubes / throat, nose, ears	<input type="checkbox"/>	<input type="checkbox"/>	Hearthburn (gastic acid)
<input type="checkbox"/>	<input type="checkbox"/>	breathless, gasping	<input type="checkbox"/>	<input type="checkbox"/>	bleedings
<input type="checkbox"/>	<input type="checkbox"/>	cough up phlegm			other: <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	chronic coughing			Muscles / Joints
<input type="checkbox"/>	<input type="checkbox"/>	asthma / bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> muscles *
<input type="checkbox"/>	<input type="checkbox"/>	sore throat / inflammation	<input type="checkbox"/>	<input type="checkbox"/>	lower back pain
<input type="checkbox"/>	<input type="checkbox"/>	sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	rustling / buzzing noise	<input type="checkbox"/>	<input type="checkbox"/>	referred pain / radiation/ pins & needles
		Heart and vascular system	<input type="checkbox"/>	<input type="checkbox"/>	pain in joints
<input type="checkbox"/>	<input type="checkbox"/>	blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> muscular *
<input type="checkbox"/>	<input type="checkbox"/>	swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	restricted movements
<input type="checkbox"/>	<input type="checkbox"/>	arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	irregular heartbeat			Skin / Hair
<input type="checkbox"/>	<input type="checkbox"/>	pain / tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> *
<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>	frequent bruises
<input type="checkbox"/>	<input type="checkbox"/>	cold hands / feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> *
<input type="checkbox"/>	<input type="checkbox"/>	varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	itching
<input type="checkbox"/>	<input type="checkbox"/>	liquid retention / oedema	<input type="checkbox"/>	<input type="checkbox"/>	brittle nails
		Urinary system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> *
<input type="checkbox"/>	<input type="checkbox"/>	kidney infection / gravel / stones	<input type="checkbox"/>	<input type="checkbox"/>	Conditions of
<input type="checkbox"/>	<input type="checkbox"/>	painful urination	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	depressions
<input type="checkbox"/>	<input type="checkbox"/>	bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	extreme anxiety
<input type="checkbox"/>	<input type="checkbox"/>	venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	lack of concentration
<input type="checkbox"/>	<input type="checkbox"/>	unusual urine	<input type="checkbox"/>	<input type="checkbox"/>	declining memory
<input type="checkbox"/>	<input type="checkbox"/>	chanced libido	<input type="checkbox"/>	<input type="checkbox"/>	anxiousness
		Women	<input type="checkbox"/>	<input type="checkbox"/>	extensive worrying
<input type="checkbox"/>	<input type="checkbox"/>	pregnant	<input type="checkbox"/>	<input type="checkbox"/>	listlessness
<input type="checkbox"/>	<input type="checkbox"/>	age of 1st menstruation	<input type="checkbox"/>	<input type="checkbox"/>	suppressed emotions
<input type="checkbox"/>	<input type="checkbox"/>	painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>	lack of self-confidence
<input type="checkbox"/>	<input type="checkbox"/>	irregular menstruation	<input type="checkbox"/>	<input type="checkbox"/>	sorrow / sadness
<input type="checkbox"/>	<input type="checkbox"/>	profuse menstruation	<input type="checkbox"/>	<input type="checkbox"/>	irresolution
<input type="checkbox"/>	<input type="checkbox"/>	painful breasts	<input type="checkbox"/>	<input type="checkbox"/>	irritation
<input type="checkbox"/>	<input type="checkbox"/>	premenstrual syndrome	<input type="checkbox"/>	<input type="checkbox"/>	hot flushes
<input type="checkbox"/>	<input type="checkbox"/>	vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	other: <input type="text"/>

Please list in chronological order of age:

1. Diseases - operations - accidents - conditions, etc. with type of treatment, including minor occurrences like spraining, dental corrections, removing tonsils, eczema, etc. Everything can be very important!
2. Diseases that you suffered as a child.
3. How many times were you pregnant and describe the course of your pregnancies?
4. Important things or changes in your life (child or adult) such as loss of family member, divorce, nervous breakdown, periods of depression, etc.
5. Visiting other countries (outside of Europe).

Age	Disease / complaint / pregnancy / changes

Apart from the above statements, have you ever had any treatment by a physiotherapist, manual therapist, specialist doctor or by any alternative medical practitioner such as an osteopath, homeopath, acupuncturist, etc.?

[Redacted text area]

Which illness was the most serious one in your life?

[Redacted text area]

Which illness was the last one before your present complaints started?

[Redacted text area]

Are your complaints worse with strong physical or psychological stress, climate changes, fever, menstruation, etc.? If so, when? :

By means of the Privacy Statement, which you received together with the confirmation of your appointment, you are explicitly informed which data your therapist stores in your client file and what your therapist does with this data.

By signing this intake form and checking the box below you agree to the privacy policy used by Mesoforte and you authorize your therapist (Patricia van Houten, Mesoloog D.M.) to store your data in order to be able to implement the requested support, as well as to comply with legal obligations.

I agree to the Privacy Policy of Mesoforte

Signature

Name

Date

Once you have filled in the questionnaire, please save it to your desktop. Then email the saved file to info@mesoforte.nl