REGISTRATION FORM

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Dear Madam, Sir,

Please read en 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:

Address:

Zip code: | City:

Date of birth: example 23-04-1980 | Place of birth:

Phone daytime: | E-mail address:

Sport & hobby:

Present occupation: | Previous occupation:

Regular diagnosis:

Family doctor: | Phone:

Specialist: | Phone:

Therapist: | Phone:

Medicine use:

How did you hear about us?

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 is 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, concerned, 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/symptoms 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.*

General

old	recent		
☐	☐	headaches:	*
		location in your head?	
☐	☐	sleeplessness	
☐	☐	difficulty to fall asleep	
☐	☐	change of weight:	*
☐	☐	dizziness	
☐	☐	fatigue:	*
☐	☐	double/blurred sight	
☐	☐	allergies	

Bronchial tubes/throat/nose/ears

☐	☐	breathless, gasping
☐	☐	cough up phlegm
☐	☐	chronic coughing
☐	☐	asthma / bronchitis
☐	☐	sore throat / inflammation
☐	☐	sinusitis
☐	☐	rustling / buzzing noise

Heart and vascular system

☐	☐	blood pressure	*
☐	☐	swollen glands	
☐	☐	arteriosclerosis	
☐	☐	irregular heartbeat	
☐	☐	pain / tightness in chest	
☐	☐	palpitations	
☐	☐	cold hands / feet	
☐	☐	varicose veins	
☐	☐	liquid retention / oedema	

Urinary system

☐	☐	kidney infection / gravel / stones
☐	☐	painful urination
☐	☐	prostate problems
☐	☐	bladder infection
☐	☐	venereal disease
☐	☐	unusual urine
☐	☐	chanched libido

Women

☐	☐	pregnant
		Age of 1st menstruation
☐	☐	painful menstruation
☐	☐	irregular menstruation
☐	☐	profuse menstruation
☐	☐	painful breasts
☐	☐	premenstrual syndrome vaginal discharge

Stomach / Abdomen

old	recent		
☐	☐	infection of intestines	
☐	☐	constipation	
☐	☐	diarrhea	
☐	☐	dry mouth	
☐	☐	abdominal distention	
☐	☐	sickness, nausea	
☐	☐	flatulence	
☐	☐	Pain / Spasms	abdominal *
☐	☐	intestinal noise	
☐	☐	Hearthburn (gastic acid)	
☐	☐	bleedings	
	other:		

Muscles / Joints

☐	☐	Tensed / Weak	muscles *
☐	☐	lower back pain	
☐	☐	neck pain	
☐	☐	referred pain / radiation /pins & needles	
☐	☐	pain in joints	
☐	☐	Pains / Spasms	muscular *
☐	☐	restricted movements	
☐	☐	rheumatism	

Skin / Hair

☐	☐	Eczema / Rash	*
☐	☐	frequent bruises	
☐	☐	Dry skin / Transpiration	*
☐	☐	itching	
☐	☐	brittle nails	
☐	☐	Losing hair / Breaking hair	*

Conditions of

☐	☐	nervousness
☐	☐	depressions
☐	☐	extreme anxiety
☐	☐	lack of concentration
☐	☐	declining memory
☐	☐	anxiousness
☐	☐	extensive worrying
☐	☐	listlessness
☐	☐	suppressed emotions
☐	☐	lack of self-confidence
☐	☐	sorrow / sadness
☐	☐	irresolution
☐	☐	irritation
☐	☐	hot flushes
	other:	

Please list in chronological order of age:

1. Diseases - operations - accidents - conditions, etc. with type of treatment, including minor occurrences like sprai-ning, 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 / symptoms / 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.?

Which illness was the most serious one in your life?

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

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

Name

Date

Signature*

* At the start of your appointment you have the possibility to digitally sign the registration form in my practice. *Therefore, you do not have to print this form at home!*

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