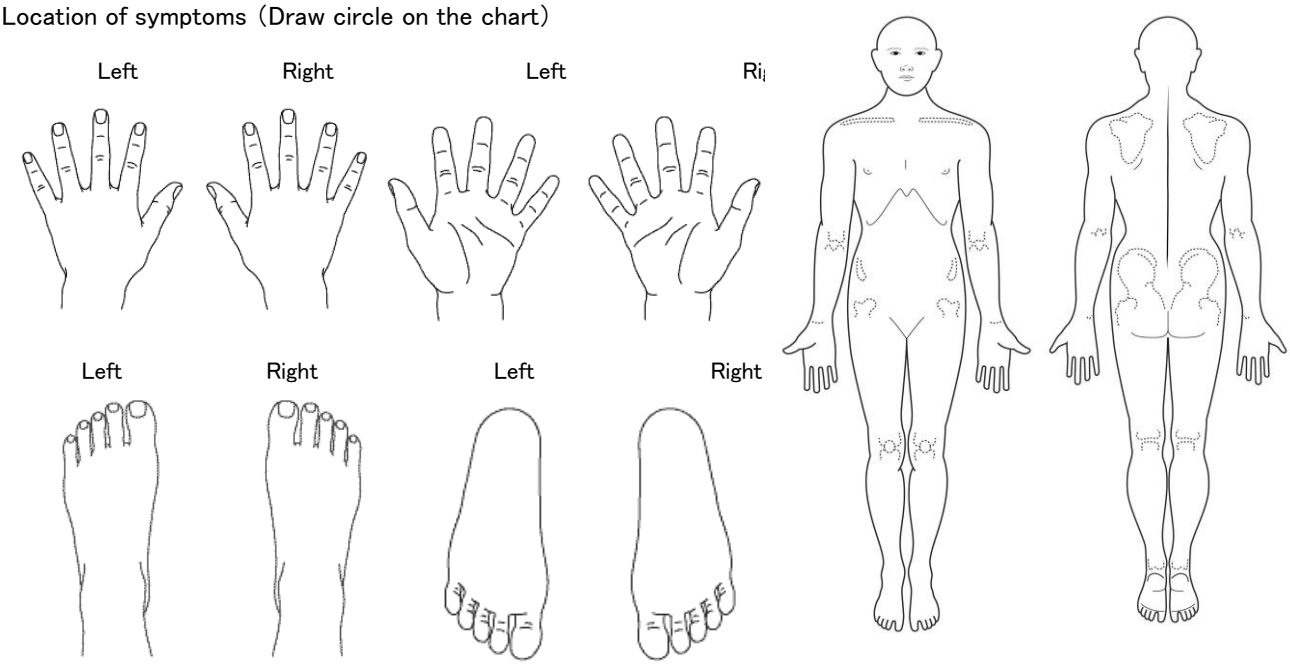
Medical Questionnaire

Name		M/F	Female patients only pregnant/not pregnant/possibly pregnant/nursing a bab
Adress	ZIP	Date of Birth / / (Age)	
	Phone:	Cellphone:	Email: @

How did you know this clinic?			
Consultation on:	General Orthopaedics /Rehab /Shoes or Braces /Dietary /Other		
What triggered your symptoms?	Unknown /Traffic accident /At work or during commute /Other( )		
Occupation	Deskwork / Standing work / Physical labor / Management / House wife / Student / Currently not working		
Do you play sports or other activities?			
What are your main symptoms?	Pain /Tingling (Pins and Needles) /Numbness /Swelling /Dullness /Deformity /Other( )		
Symptoms present since		height( )cm	weight( )kg
Change in symptoms	Improving/No change/Worse	What was your first symptoms at onset?	

Location of symptoms (Draw circle on the chart)



What activity worsens your symptoms?				
What activity improves your symptoms?				
Past treatment in other hospitals/ clinic	When	hospital	diagnoses	treatment

Your health history	Nothing in particular Yes: apoplexy / diabetes / dyslipidemia / hypertension /heart disease / mental disorder / asthma / Rheumatoid arthritis /bone fracture Other( )
Allergy	①No ②Unknown ③Yes( )
Any other concerns?	