Answer the questions to the best of your ability.
If in doubt, go to the next question.
The practitioner will ask about your answers during the consultation.

1. **Name:** _____

2. **CPR:** ___ ___ ___ ___ ___ ___ -- ___ ___ ___ ___ **Member of health insurance "danmark"?** Yes__ No__

3. **Email:** _____

4. **Do you have health insurance**? (not including "danmark") Yes___ No___

5. **Consent to share information with your general practitioners (including X-rays)** Yes__ No ___

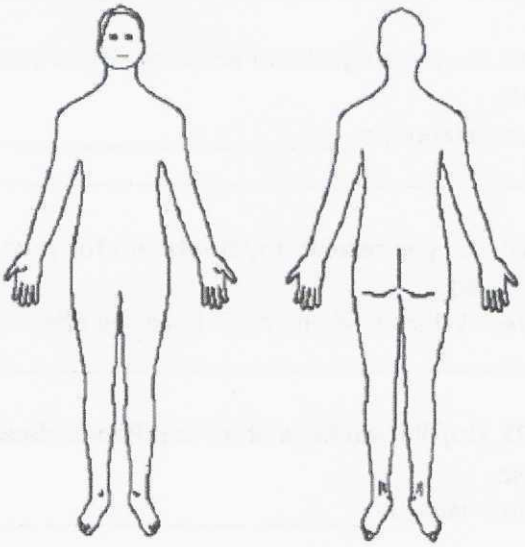
6. **Consent to gather relevant diagnostic imaging from hospitals / X-ray Clinics** Yes__ No ___

7. **Consent to share relevant health information with other associated practitioners** Yes__ No ___

8. **Primary complaint location** (write AND mark on the figure)

_____

_____



9. **When did the present complaint start?**

Approx. date ___ ___-___ ___-___ ___ ___ ___
day month year

10. **Initial presentation of complaint**
Slowly, insidious:____
Abruptly:____

11. **Cause of complaint**?
Unknown____
Known cause (write): _____
_____

12. **Pattern during the day**?
Worse morning:____
Worse evening: ____
Worse during the day:____
No pattern:____

13. **Pain/Symptom intensity** (Mark with an X on the line - don't write in numbers)
Right now:
No pain Worst imaginable pain
0 _____ **100**
During the last week:
No pain Worst imaginable pain
0 _____ **100**

14. **Medication** (For this complaint **AND** other conditions)

Name:	Dosage:	Number:	Effect: None	Some	Good
1 _____	_____	____	____	____	____
2 _____	_____	____	____	____	____
3 _____	_____	____	____	____	____
4 _____	_____	____	____	____	____

TURN!

15. Pain/complaint characteristics? (For instance throbbing, sharp, electric, burning, stiffness, etc.)

_____

16. Triggering positions, movements or activities?

_____

_____

17. Relieving positions, movements or activities?

_____

_____

18. Did you experience the complaint previously?

No____

Yes- How often? _____

19. Previous injuries or accidents ? (for instance motor vehicle accident, fractured ribs, dislocated shoulder)

No____

Yes, elaborate:_____

_____

20. Did you receive any treatment for your present complaint?

No____

Yes - Which kind and did it have any effect?_____

_____

21. Do/did you have other conditions/diseases (for instance cancer, arthritis, osteoporosis, other pathologies)

No____

Yes - Which? _____

_____

22. Do any family members have complaints in the same area?

No____

Yes - Who? (if you know) _____

23. Any previous hospitalization or surgery? (Any regions)

No____

Yes - When and what for? _____

_____

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

25. Occupation (present/past) _____

26. Are/were you on sick leave for present complaint?

No____ Yes - How long? _____

27. Do you exercise/play sports?

No____

Yes - Which and how frequently?_____

28. Did you have any prior relevant diagnostic imaging (MRI, x-rays, other)?

_____

29. Who recommended the clinic to you?

GP____ Colleague ____ Family____ Friend____ Other_____

30. Date: _____/_____/_____ **Signature:** _____