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| Intake formulier volwassen | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Algemeen persoonlijke gegevens | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Naam: | | | |  | | | | | | | |  | | | | | | | | Geboortedatum: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Voornaam | | | |  | | | | | | | |  | | | | | | | | Email adres: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Adres | | | |  | | | | | | | |  | | | | | | | | Telefoonnr: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Postcode | | | |  | | | | | | | | Woonplaats | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
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| Medische gegevens | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Huisarts: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bent u onder de behandeling van een specialist/ therapeut, naam: | | | | | | | | | |  | | | | | | | | | | | | Specialisatie | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Door wie bent u geïnformeerd/ geadviseerd? | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
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| Gebruikt u op dit moment medicatie? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Naam | | | | Merk | | | | | | | | Gebruik | | | | | | | |  | | | | | | | | | | | | | | Hoeveelheid | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | |  | | | | | | | | X daags | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
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| Gebruikt u andere middelen die u zijn voorgeschreven door anderen of op eigen intitiatief, bijvoorbeeld voedingssupplementen, paracetamol, neusspray of slaaptabletten/ Gelieve deze 24 uur voor het consult niet meer in te nemen. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Naam | | | | Merk | | | | | | | | Gebruik | | | | | | | |  | | | | | | | | | | | | | | Hoeveelheid | | | | | | | | | | | | | | |
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| Graag de medicatie en supplementen bij het consult meebrengen | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Leefsituatie | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wat is uw beroep: | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Wat waren uw vorige werkzaamheden: | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Wat doet u voor hobby/ sport/ vrije tijd: | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Aanvulling: | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
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| Klachten | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wat is uw voornaamste klacht: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Welke bijkomende klachten heeft u: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wanneer is/ zijn deze ontstaan: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Was er een aanleiding: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hoe uit(en) zich deze: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Welke cijfer zou u uw gezondheid geven | | | | | | | | | |  | | | | | | | | | | | | Van 1 tot 10 (1 is slecht, 10 is uitstekend | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Zijn er omstandigheden die verbetering geven: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Zijn er omstandigheden die verslechtering geven: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is er een regelmaat of patroon te ontdekken: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is/zijn uw klacht(en) periode afhankelijk, bijv tijd, dag, maand, seizoen: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Heeft u pijn: | | | | Ja | | | | | | | | Nee | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Zo ja, wat is de aard van de pijn | | | | Stekend | | | | | | | | Brandend | | | | | | | | Zeurend | | | | | | | | | | | | | | Schietend | | | | | | | | | | | | | | |
|  | | | | Kloppend | | | | | | | | Dof | | | | | | | | Snijdend | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Aanvulling: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Persoonlijke kenmerken | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Hoe voelt u zich in het algemeen: | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Zijn er gedurende de dag momenten van inzinking: | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Kunt u gemakkelijk inslapen | | | | Ja | | | | | | | | Nee | | | | | | | | Wordt u s’nachts wakker, hoe laat: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | uur | | | | | | |
| Frequentie van de stoelgang | | | |  | | X daags | | | | | |  | | x per week | | | | | | Regelmatig | | | | | | | | | | | | | | Onregelmatig | | | | | | | | | | | | | | |
| Consistentie van de stoelgang | | | | Vast | | | | | | | | Brijig | | | | | | | | Zacht | | | | | | | | | | | | | | Waterig | | | | | | | | | | | | | | |
| Kleur van de stoelgang | | | | Wit | | | | Lichtbruin | | | Geelbruin | | | | | | | | | Donkerbruin | | | | | | | | | | Zwart | | | | | | | Groen | | | | | | | | | | | |  | | | | | | |
| Transpireert u: | | | | Veel | | | | Weinig | | | | | | | Niet | | | | | Sterk ruikend | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | |  | | | | | | |
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| Graag aankruisen waarin u zichzelf herkent: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Angstig | | | | Boos | | | | | | | | Perfectionist | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Hyperactief | | | | Verdrietig | | | | | | | | Gejaagd | | | | | | | | Cijfer mezelf snel weg | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Depressief | | | | Snel schuldgevoel | | | | | | | | Stressgevoelig | | | | | | | | Veel zelfvertrouwen | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Opkroppen | | | | Blij | | | | | | | | Bezorgd | | | | | | | | Weinig zelfvertrouwen | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Historie en familie | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Welke ziekten, operaties, behandelingen en/of emotionele gebeurtenissen heeft u in uw leven doorgemaakt? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Welke ziekte of aandoening was het zwaarst in uw leven | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Welke kinderziektes heeft u doorgemaakt | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Heeft u antibiotica gebruikt: | | | | | | | | | | 1 keer | | | | | | | | | | | regelmatig | | | | | | | | | | Heel vaak | | | | | | | | | | | | | | | | | | langdurig | | | |
| Heeft u buiten Europa gereisd: | | | | | | | | | | ja | | | | | | | | | | | nee | | | | | | | | | | Zo ja, waar | | | | | | | | | | | | | | | | | |  | | | |
| Heeft u vaccinaties gehad ivm | | | | | | | | | | reizen | | | | | | | | | | | griep | | | | | | | | | | Rijksvaccinatie | | | | | | | | | | | | | | | | | | Corona | | | |
| Bent u in het verleden eerder onder behandeling geweest van een therapeut/ specialist (bijv. internist, cardioloog, homeopaat etc)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Welke ziekten en/of aandoeningen (wel of niet erfelijk) komen in uw familie voor: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Moeder: | | | |  | | | | | | | | | | | | | | | | Vader: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Anders: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Voedingsgewoonten | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Eet u: | | | | Vegetarisch | | | | | | | | Veganistisch | | | | | | | | | | | Anders | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | |
| Heeft u voorkeur voor: | | | | Zoet | | | | | | | | Zout | | | | | | | | | | | Zuur | | | | | | | | | Pikant | | | | | | | | | | | | | | Bitter | | | | | |
| Heeft u afkeur voor: | | | | Zoet | | | | | | | | Zout | | | | | | | | | | | Zuur | | | | | | | | | Pikant | | | | | | | | | | | | | | Bitter | | | | | |
| Welke voedingsmiddelen of dranken verdraagt u niet goed: | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heeft u grote behoefte aan zoetigheid | | | | | | | Ja | | | | | | | | | | | | Nee | | | | | | | | | | | Wat neemt u dan: | | | | | | | | | | | |  | | | | |
| Drinkt u koffie: | | | | | | | Ja | | | | | | | | | | | | Nee | | | | | | | | | | | Hoeveel: | | | | | | | | | | | |  | | | | |
| Drinkt u alcohol: | | | | | | | Ja | | | | | | | | | | | | Nee | | | | | | | | | | | Wat en hoeveel: | | | | | | | | | | | |  | | | | |
| Rookt u: | | | | | | | Ja | | | | Nee | | | | | | | | | Hoeveel | | | | | | | | |  | | | | | | Hoe lang: | | | | |  | | | | | | | | |
| Gebruikt u drugs? | | | |  | | | | | | | | Ja | | | | | | | | | | | Nee | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | |
| Aanvulling: | | | |  | | | | | | | |  | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | |
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| Allergie/ overgevoeligheden | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heeft u weleens een koortslip | | | | | | | Ja | | | | | | | | | Nee | | | | | | | | |  | | | | |  | | | | | | |  | | | | | | | | | | | |
| Allergie/overgevoeligheid voor | | | | | | | gluten | | | | | | | | | | koemeleiwit | | | | | | | | | lactose | | | | | | | | | | | hooikoorts | | | | | | | | huisstofmijt | | | | | |
|  | | | |  | | | | | | | | vruchten | | | | | | insecten | | | | | | | | | sieraden | | | | | | | | | | | | paracetamol | | | | | | | | | antibiotica | | | | | |
| Aanvulling | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Algemeen | | | | Vroeger | | | | | | | | Nu | | | | | | | |  | | | | Spijsvertering | | | | | | | | | | Vroeger | | | | | | | | | | Nu | | | | | |
| Migraine | | | |  | | | | | | | |  | | | | | | | |  | | | | Buikkramp | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Duizeligheid | | | |  | | | | | | | |  | | | | | | | |  | | | | Misselijkheid | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Slechte concentratie | | | |  | | | | | | | |  | | | | | | | |  | | | | Winderigheid | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Slecht geheugen | | | |  | | | | | | | |  | | | | | | | |  | | | | Borrelende buik | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Gewichtsverandering | | | |  | | | | | | | |  | | | | | | | |  | | | | Obstipatie | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Toename | Afname | | |  | | | | | | | | | | | | | | | |  | | | | Diarree | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Vermoeidheid | | | |  | | | | | | |  | | | | | | | | |  | | | | Bloed bij de ontlasting | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Continue | | ochtend | | | middag | | | | | | | | avond | | | | | | |  | | | | Slijm bij de ontlasting | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Zichtvermogen | | | |  | | | | | | |  | | | | | | | | |  | | | | Droge mond | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Vaag zien | | Dubbel zien | | | staar | | | | | | | | nachtblind | | | | | | |  | | | | Slechte adem | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Hoofdpijn: | | | |  | | | | | | |  | | | | | | | | |  | | | | Opgeblazen gevoel | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Dagelijks | | | wekelijks | | | | | | maandelijks | | | | | | | | | | |  | | | | Brandend maagzuur (reflux  ) | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| Waar in het hoofd heeft u pijn: | | | |  | | | | | | | | | | | | | | | |  | | | | altijd | | | | | | | | | | Na de maaltijd | | | | | | | | | | S’nachts | | | | | |
| Aanvulling: | | | |  | | | | | | | | | | | | | | | |  | | | | Anus | | | | jeuk | | | | | kramp | | | aambeien | | | | | | |  | | | | | | | | | | | |  | |
|  | | | |  | | | | | | | | | | | | | | | |  | | | | Veel speeksel/ kwijlen | | | | | | | | | |  | | | | | | | | | |  | | | | | |
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| Circulatie | | | | | | Vroeger | | | | | Nu | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
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