Atlas Zone Therapie Praktijk drs. Wim van den Berg

Intake Form

Please read and sign the statement of informed consent; answer all questions on pages 2 and 3 and read the terms of payment. If you need more space, use an extra sheet. All provided information will be kept strictly confidential; it will not be shared with other therapists, physicians or anyone, except with your written permission.

First name: .... Last name: ....

Your insurance number: .... with: ....
Insurance company Uzovi code

Date of birth: .... Gender: ....

Marital status: .... Profession: ....

Address: ....

Postal code: .... Town: ....

Telephone: .... Mobile phone: ....

Email address: ....

☐ I agree to receive a newsletter about Atlas Zone Therapie once or twice a year.

Statement of Informed Consent

I, the undersigned, will answer the questions on pages 2 and 3 to the best of my knowledge. I understand that I can give more information orally during the interview. I have seen, heard, and understood the information that was provided about Atlas Zone Therapie.

I understand that Atlas Zone Therapie does not replace medical diagnoses or treatments and that it is not necessary to interrupt, postpone, or cancel any prescribed or ongoing medical treatments to receive the Atlas Zone treatment. It is wholly my own responsibility to continue or discontinue ongoing therapies and prescriptions, and to receive the Atlas Zone Therapy.

I have read and agree to the privacy statement on the website (www.atlaszone.nl) which is also available in the Practice.

I am aware that not all insurance policies cover the fee for Atlas Zone Therapie and I will not hold Praktijk drs. Wim van den Berg responsible in case my treatment is not covered by my insurance. I accept the terms of payment on page 3 of this form.

I request Atlas Zone therapist: ☐ drs. Wim van den Berg ☐ Jolanda Oosterwolde
to treat me with Atlas Zone Therapy.

Date: .... Name of person treated: .... Signature: ....
(Also children should sign if aged 12 or older.)

Date: .... Name: .... Signature: ....

Date: .... Name: .... Signature: ....
(Both parents/legal representatives sign for children under 16.)

Signed for compliance with VIV regulations *(by the therapist)*: ....

To be completed by the therapist:

I: / /2023 W J	II: / /2023 W J	P C	€

Questionnaire

Have you ever had an accident? ☐ No ☐ Yes, in: .... (year) Please describe:

....

....

Is there any problem or pain in your spine or neck? ☐ No ☐ Yes: ....

....

Is there any problem or pain in your pelvis or tailbone? ☐ No ☐ Yes

Please describe treatments you have had for your spine, neck, pelvis or tailbone: ....

....

....

When were you treated most recently / Do you have treatments scheduled? ....

Do you use corrective soles? ☐ No ☐ Yes, since: ....

Do they compensate for a difference in the length of your legs? ☐ No ☐ Yes

Have you had surgery during the last 5 years? ☐ No ☐ Yes, for: ....

....

Were you born naturally, without complications? ☐ Yes ☐ No: ....

.... (Caesarean section, breech birth, ventouse, etc.)

Do you suffer from migraine or headaches? ☐ No ☐ Yes. How often?

....

Are you having medication or treatment for this? ☐ No ☐ Yes: ....

....

Have you ever suffered from depression? ☐ No ☐ Yes. During which periods of your life?

....

Are you taking medication for depression? ....

Do you take any medications in addition to the above-mentioned? ☐ No ☐ Yes, for:

....

Note: If you are receiving chemo or radiation therapy, it is advised to postpone Atlas Zone treatment until that therapy is completed.

Are you pregnant? ☐ No ☐ Yes

Are you left-handed or right-handed by nature? ☐ right-handed ☐ left-handed

Do you wear glasses? ☐ No ☐ Yes ☐ Only for reading

Do you wear contact lenses? ☐ No ☐ Yes *(Please remove them before treatment.)*

When did you last have your eyes checked? ....

Do you experience eye pressure or tension? ☐ No ☐ Sometimes ☐ Frequently

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Do you grind your teeth during sleep? ☐ No ☐ Yes, since: ....

Do you experience jaw discomfort or pain? ☐ No ☐ Yes, since: ....

Do you suffer from indigestion regularly? ☐ No ☐ Sometimes ☐ All

Do you experience spells of dizziness? Do ☐ No ☐ Sometimes ☐ Frequently

you suffer from nausea? ☐ No ☐ Sometimes ☐ Frequently

Do you experience difficulty in concentrating? ☐ No ☐ Sometimes ☐ Frequently

What is your memory like? ☐ Good ☐ Average ☐ Poor

Do you suffer from tinnitus? ☐ No ☐ Mild ☐ Severe

Please describe any other health problems you may have? ....

....

....

How is your blood pressure? ☐ Normal ☐ Too high ☐ Too low

Do you experience discomfort while walking? ☐ No ☐ Mild ☐ Severe

Do you have difficulty performing everyday activities, or are there everyday activities you can't do at all? ☐ No ☐ Yes: ....

....

Do you find you always have some pain in the body? ☐ No ☐ Yes

How frequently do you visit your general practitioner? ....

Are you currently receiving treatment from a specialist? ☐ No ☐ Yes

How is the quality of your sleep? ☐ Good ☐ Average ☐ Poor

How many hours do you usually sleep at night? ....

Do you usually sleep in the prone position? ☐ Yes ☐ No

Do you take regular physical exercise? ☐ Yes ☐ Sometimes ☐ No

Have you had a treatment of the Atlas vertebra before? ☐ No ☐ Yes, by:

.... in: .... (month, year)

It is significant for our diagnosis to know whether your Atlas has been treated before, either with Atlas Zone Therapy or with any other method.

Terms of payment

The fee for Atlas Zone Therapie is €395 for adults, €295 for children under 16. The treatment includes two sessions. Normally, the full fee is paid at the first session, in cash or by bank card. After the second session, you'll receive the invoices for your health insurance, in case they reimburse. The fee for any additional later checkup session is €100.