

Praktijk drs. Wim van den Berg

De Vloot 206 C, 3144 PK Maassluis, The Netherlands · Phone: +31 642 679 638

Atlas Zone
Therapy



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 else, except with your written permission.

First name: Last name:

Your insurance number: at: Insurance company Uzovi code

Date of birth: Gender:

Marital status: Profession:

Address:

Postal code: Town:

Telephone: Mobile phone:

Email address:

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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 the Atlas Zone Therapy.

I understand that Atlas Zone Therapy 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 Atlas Zone Therapy. It is wholly my own responsibility to continue or discontinue ongoing therapies and prescriptions, and to receive Atlas Zone Therapy.

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

I am aware that not all insurance policies cover the fee for Atlas Zone Therapy 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 or legal representatives sign for children under 16.)



Signed for compliance with VIV regulations:

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 *If you are pregnant, Atlas Zone Therapy should be postponed.*

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

-> p. 3

- Do you grind your teeth during sleep? No Yes, since:
- Do you experience jaw discomfort or pain? No Yes, since:
- Have your wisdom teeth been removed? No Sometimes All
- Do you experience spells of dizziness? No Sometimes Frequently
- Do 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 Therapy is €225 for adults and €165 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 3 invoices for your health insurance, in case they reimburse.

Praktijk drs. Wim van den Berg, De Vloot 206 C, 3144 PK Maassluis, The Netherlands

Phone: +31 642 679 638 · Email: info@atlaszone.nl · AGB code (Practice): 90057095

Registrations Jolanda: AGB codes: 90049413 · VIV 1907933B · RBCZ 180012R

Registrations Wim: AGB 90048569 · VIV 1907768B · RBCZ 505104R · MBK (W.O. 18m) · PSBK (W.O. 5p)
