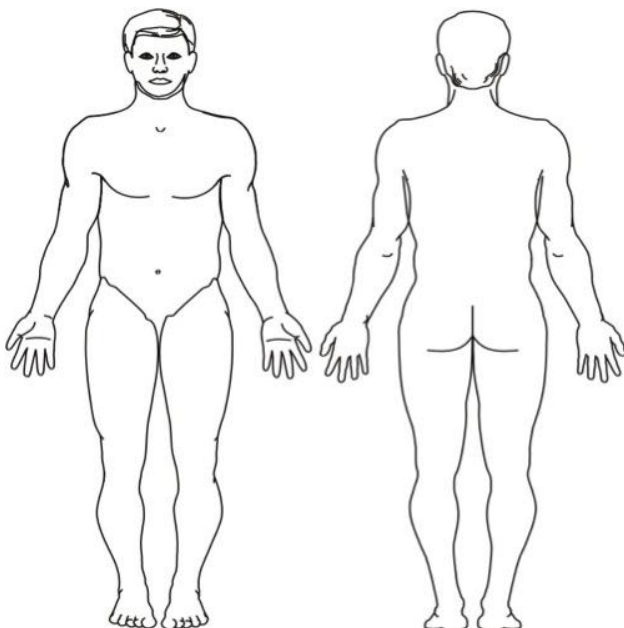


General Information	
Family name:	Date of birth:
First name:	Occupation:
Street:	Tel. private / mobile:
Post / Zip Code:	Tel. business:
City:	E-Mail:
Health Insurance: <input type="checkbox"/> Private <input type="checkbox"/> Legal	

How did you find us?
<input type="checkbox"/> Recommendation of patient:
<input type="checkbox"/> Recommendation of Doctor, Physiotherapist, Midwife....
<input type="checkbox"/> Internet
<input type="checkbox"/> Our Health Class

Medical information
Are you in pain at the moment? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, on a scale from 1 (little) to 10 (insufferable)?
Where are you feeling the pain / symptoms? (Please mark in the drawing)



When did the symptoms start? (days, months, years)	
Did you have the symptoms in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you excused from work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please tell us the period:	
Have you had other treatments because of these symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, where / with whom? (Doctor, Physio...)	
Do you have x-ray, CT or MRI pictures	<input type="checkbox"/> Yes <input type="checkbox"/> No

Yes	No	Do you suffer from?
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Migraine
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Visual disorder
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection
<input type="checkbox"/>	<input type="checkbox"/>	Jaw problems
<input type="checkbox"/>	<input type="checkbox"/>	Swallowing problems
<input type="checkbox"/>	<input type="checkbox"/>	Concentration problems
<input type="checkbox"/>	<input type="checkbox"/>	Tiredness
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Lack of appetite
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss
<input type="checkbox"/>	<input type="checkbox"/>	Sickness
<input type="checkbox"/>	<input type="checkbox"/>	Breathing problems
<input type="checkbox"/>	<input type="checkbox"/>	Heart burn / acid reflux
<input type="checkbox"/>	<input type="checkbox"/>	Gastro- / Intestinal afflictions

Yes	No	Have or did you have the following diseases?
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism / Gout
<input type="checkbox"/>	<input type="checkbox"/>	Cardio-vascular disease
<input type="checkbox"/>	<input type="checkbox"/>	Infectious disease
<input type="checkbox"/>	<input type="checkbox"/>	Heritable disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Other disease:

Yes	No	Are you taking medication?
<input type="checkbox"/>	<input type="checkbox"/>	Blood thinner
<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure corrective
<input type="checkbox"/>	<input type="checkbox"/>	Pain reliever (nonprescription)
<input type="checkbox"/>	<input type="checkbox"/>	Pain reliever (prescription)
<input type="checkbox"/>	<input type="checkbox"/>	Hormone s (e.g. Cortisone)

Yes	No	Are you suffering from injuries caused by:
<input type="checkbox"/>	<input type="checkbox"/>	Car accident
<input type="checkbox"/>	<input type="checkbox"/>	Sports accident
<input type="checkbox"/>	<input type="checkbox"/>	Bone fracture
<input type="checkbox"/>	<input type="checkbox"/>	Have you had operation? If yes, where:
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any permanent injuries from these operations? If yes, which:

Yes	No	Only for women:
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cramps
<input type="checkbox"/>	<input type="checkbox"/>	Gynecological problems
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Did you have pelvis / back problems during / after pregnancy?

Which sports do you do?
Further information you like to give us?

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

**Chiropraktik Praxis Westend**  
Günther Sasse  
Im Trutz 49  
60322 Frankfurt

### **Information**

The following details are to clarify possible risks, or side effects and our treatment procedures.

#### **Treatment risks:**

Carried out by a qualified chiropractor (with a minimum of 5 years academic education) chiropractic is a safe form of treatment. Studies came to the result that the risk of an injury in the lumbar spine area is with 1:100 000 very low. The risk of damaging the vertebral artery (Arteria Vertebralis) in the cervical spine and a following stroke is with 6:10 000 000 even much lower. Our treatments are individual, always considering the most of our patients' health condition, therapeutic need and physical capability.

#### **Treatment reactions:**

After a chiropractic treatment the muscles in the adjusted area can feel stiff or sore which may appear within hours up to a few days after the treatment. This kind of pain usually fades soon if locally cooled with an ice compress. Temporary tiredness and/or headache may appear sometimes accompanied with light dizziness and/or sickness. The treated zone may feel a little instable.

#### **Appointments:**

Because of our very precise schedule we depend on your punctuality. Please inform us at least one day prior to the agreed time if you cannot maintain an appointment so the open time slot can be passed on to other patients. Otherwise we reserve the right to charge for not showing for an appointment.

#### **Treatment costs:**

We need you to pay for our treatments as chiropractic is not covered by the legal health care. Therefore please contact our reception. If you wish you will receive an invoice for your private health insurance at any time.

Please don't hesitate to contact us for further information.

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I have read the text above and feel well informed about chiropractic

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Date

Name (block letters)

Signature