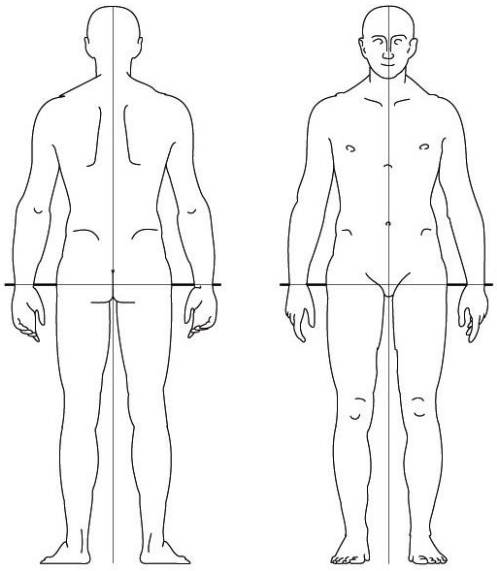
Patient History Form

Personal Information	
Family name:	Date of birth:
First name:	Job / Occupation:
Street:	
Post / ZIP Code:	City:
Tel. private:	Tel. business:
E-Mail:	
Health Insurance: □ Legal □ Private □ Supplementary	
How did you hear about us: □ Recommendation by: □ Internet □ Other:	

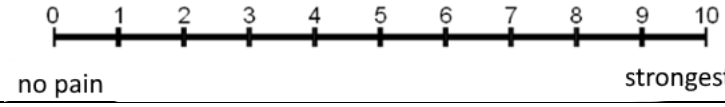
Chief Complaints:
What are your current chief complaints:
Where do you have the complaints - please mark on the diagram: 
Since when have you had these complaints:
The complaints □ first appeared □ have been known since:
Was there a cause for the complaints: □ no yes: □ Accident □ Fall □ Surgery □ Journey □ Unknown □ Other:
Can the complaints be influenced by specific measures: □ no yes: ... improves with: ... worsens with:

Are the complaints □ always present □ intermittently absent □ never completely gone or □ occurring differently:

How do the complaints show: □ Pain □ Tingling □ Numbness □ Throbbing □ Burning □ Swelling □ Redness □ Muscle weakness □ Other:

Are the complaints □ only local or □ radiating to other areas:

How severe are your complaints on a scale of 1 to 10 – please mark:



Have you already received treatment for the complaints: □ no yes, from:

□ MD □ Heilpraktiker □ Osteopath □ Chiropractor □ Physiotherapist □ Other:

Which diagnosis was made:

Do you have any X-ray, CT or MRI images (with you): □ yes □ no

Are you taking medication for your *current complaints*: □ no yes:

□ Painkillers:
□ Anti-Inflammatories:
□ Other Medication:

Further Complaints and Conditions:

Do you have any other current or recurring complaints:
□ no yes, please tick:

□ Eye / Vision Problems
□ Sinusitis / Sinus infections
□ Headaches / Migraine
□ Dizziness / Balance Disorder
□ Tinnitus (Ear Noise)
□ Circulatory Weakness / Fainting
□ Concentration Weakness / Tiredness / Fatigue
□ Yesw Complaints (Grinding, CMD)
□ Shoulder / Neck Pain
□ Chest Pain / Palpitations of the Heart
□ Back Pain / Lumbago
□ Arm Pain (□ with or □ without Tingling / Numbness)
□ Leg Pain (□ with or □ without Tingling / Numbness)
□ Foot Pain (□ with or □ without Tingling / Numbness)
□ Digestive Complaints
□ Bladder Complaints
□ Other Complaints:

Do you suspect a connection to your chief complaints:
□ no □ yes:

Did you have or do you have any other pre-existing conditions or diseases:
□ no yes, please tick:

□ Arteriosclerosis (Vascular Calcification)
□ Diabetes Mellitus (High Blood Sugar Levels)
□ Dyslipidemia (Cholesterol)
□ Blood Pressure Disorder (Hypertension / Hypotension)
□ Heart Disease / Heart Attack
□ Brain Disease / Stroke
□ Blood Coagulation Disorders
□ Thyroid Disease
□ Respiratory Issues (Asthma, Bronchitis, Pneumonia)
□ Arthritis (Joint Inflammation, Gout)
□ Arthrosis (Joint Degeneration)
□ Rheumatism
□ Osteoporosis (Low Bone Density)
□ Scoliosis (Spinal Curvature)
□ Scheuermann's Disease (Adolescent Kyphosis)
□ Herniated Disc (Disc Prolapse)
□ Tear of Ligaments/Tendons/Muscles
□ Bone Fracture
□ Infectious Diseases
□ Skin Diseases
□ Mental Illness
□ Cancer/Tumor:
□ Prostate □ Breast □ Colon □ Lung □ Other:
□ Other Diseases:

Are you taking medication for your *conditions or diseases*: □ no □ yes, these:

Are there any family medical histories of diseases among parents, siblings, or children: □ no
□ yes:

Have you had any (severe) accidents or falls: □ no
yes: What? When?

There were scars or other complications: □ no □ yes:

Have you had any surgeries: □ no
yes: Was? Wann?

There were scars or other complications: □ no □ yes:

□ Screws □ Plates □ Prostheses □ Others were implanted.

Vegetative System:
Do you suffer from general susceptibility to infections or allergies: □ no □ yes:
What is your daily water intake (liters/day):
What do you eat: □ Mixed diet □ Vegetarian □ Vegan □ Other:
Do you have digestive problems: □ no yes: □ Bloating □ Abdominal pain □ Diarrhea □ Constipation □ Irritable Bowel Syndrome (ITB) □ Heartburn □ Antibiotic-related issues □ Other:
Do you have food intolerances: □ no yes: □ Gluten/Celiac disease □ Lactose □ Fructose □ Histamine □ Other:
Do you have trouble getting a restful sleep: □ no yes: □ Difficulty falling asleep □ Difficulty staying asleep □ Snoring □ Teeth grinding □ Other:
Do you suffer from increased stress □ currently or □ over a longer period: □ no yes: □ Work □ Studies □ Private life □ Other:
Do you engage in sports or other activities in your free time: □ no □ yes:
Do you regularly consume stimulants/drugs: □ no yes: □ Alcohol □ Nicotine □ Cannabis □ Other: How much daily: Since when:
Do you regularly take vitamins, pre-/probiotics, or dietary supplements: □ no □ yes:
Do you notice any of the following symptoms in yourself: □ Weight loss (>10% in the last 6 months) □ Newly developed aversion to meat and sausage □ Night sweats □ Fever (>38°C)

For Females:

Is there currently a possibility of pregnancy: □ no □ yes

Have there been any previous pregnancies or births: □ no

yes: □ Natural Birth □ Cesarean Section □ Miscarriage □ Others:

Do you still get your period:

□ yes: □ regularly □ irregularly

□ no: □ Menopause □ Hormonal treatment □ Unknown □ Other:

Do you regularly go for check-ups with your gynecologist:

□ no □ yes:

Did you have or do you have any other gynecological complaints:
□ no yes, please tick:

□ Menstrual problems
□ Menopausal problems
□ Changes in the breast / Breast cancer
□ Vaginal yeast infection
□ Urinary tract or bladder infections
□ Bladder weakness / Incontinence
□ Ovarian / Fallopian tube inflammation
□ Endometriosis
□ Ovarian cyst
□ Other:

Have your symptoms been treated with an antibiotic: □ no □ yes

Have you had gynecological surgeries: □ no

yes: When? What?

Were there any complications: □ no yes, please tick:

□ Scars
□ Inflammations
□ Adhesions
□ Other: