Dear Patients, With this questionnaire you facilitate us for the possible causes of your complaints. They provide us with important information for your treatment. All information is strictly confidential and serves your treatment.

Name: Birth:

Street: Code – City:

Mobile.: E- Mail.:

Insurance: Job:

Hobbies/ Sports:

1. **Are you currently in the following occupational groups in treatment** ?

☐ General ☐ Orthopedic ☐ Osteopath ☐ Dentist ☐ Psychologist ☐ Others

2. **On what symptoms you have been treated in the past 10 years medical / therapeutic:**

3. Have you ever had any of these conditions diagnosed?

Motion system (bone fracture, ligament rupture, etc.)? ☐ yes, which one:

Cardiovascular system (hypertension, heart attack etc.)? ☐ yes, which one:

Respiratory system (asthma, COPD, etc.)? ☐ yes, which one:

Nervous system (paralysis, stroke, Parkinson's, etc.)? ☐ yes, which one:

4. Do you have allergies (medications, latex)? Which:

5. Please list all the operations that you had (Specifying Initial and date)

6. **Which of the following medications you have taken in the last week:**

Painkillers	☐ no	☐ yes: medically prescribed / non-prescribed
Inflammatories	☐ no	☐ yes: medically prescribed / non-prescribed
Muscelrelaxate	☐ no	☐ yes:medically prescribed / non-prescribed
Psychotropic	☐ no	☐ yes: medically prescribed / non-prescribed
Others	☐ no	☐ yes, which one

Please turn

5. **What complaints have led to us? Please describe:**

6. **When did the symptoms started, have there been a trigger? Did the pain change until today?**

7. **Do the symptoms change during the day?**

10. **In what posture (for example, while sleeping, sitting, walking) complaints are at their worst?**

Where on a pain scale to "10" ranges from "0" for complete freedom from pain for the worst imaginable pain, you would enter your pain?

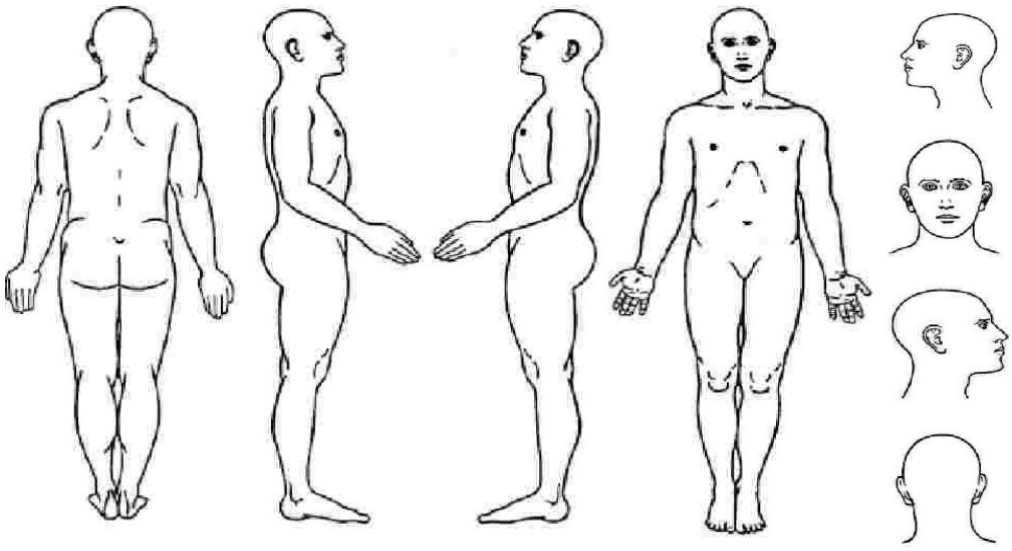
☺ ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☹

11. **Pain quality: briefly describe their pain (for example, acrid, burning, superficial, spasmodic, wavy)**

12. **What symptoms do you have expet from pain (for example, pins and needles, numbness works, something's not right, dizziness, insomnia, weight loss, etc.)?**

Draw on the sketch a please where you have pain anywhere

Go your pain from a given area from, mark it with a (X), the direction of emission with a (→)



For statutory insured patients: ☐ I am aware of the fact that insured persons are obliged to pay an additional fee. (For example: 10, - € per prescription + 10% of the prescription value, please bring in cash)

I have been physiotherapy for the last 12 weeks: ☐ Yes ☐ No

I agree that my data will be processed, stored and forwarded to the Schweriner Rechenzentrum für Heilberufe.

For private patients: (You will be informed of the exact remuneration rates in the fee agreement.)

If you want a form of treatment that you have not been prescribed by the doctor or whose cost assumption is not guaranteed, you can of course use the service as a self-payer.
Further information can be found at www.noraphysio.de/infos/.

I agree that my data will be processed and stored.

How did you find us? ☐ Google ☐ Doctor ☐ Recommendation/ friends ☐ Others

Cancellation / cancellation fee agreement:

Since we are an exclusive appointment practice, it is imperative that you cancel imperceptible appointments at least 24 hours in advance. A shorter cancellation or not taking the appointment will be charged for each appointment unperceived a blanket cancellation fee in the amount of 25.00 EUR on the bill.

Noted:

(place, date) (signature patient)