Entrance questionnaire to medical history

Dear / r patient, please answer the following questions. Thanks!

Name: _____ Birth: _____

Street:_____City code:_____

Phone: _____ Email .: _____

Job: _____ Hobbies / Sports:

General Questions

1. You work on time? Activity? If not, what is your profession (also housewife)?

2. Do you do sport activities? What kind? How often?

3. If you have pre-existing conditions (heart attack, osteoporosis, cancer, diabetes, hypertension, allergies)?

4. Do you have other symptoms? (Digestive, pulmonary, ENT, genitourinary, thyroid ...)?

5. Did you have a serious illness in your childhood; any problems when you were born?

6. For women only: you have given birth to children? How many? Were there any problems (for example, Caesarean section, sciatica ...)?

7. Did you have accidents (or similar violently, fall on the buttocks, twisting, car accident)? When? Effects?

8. Have you had surgery (also wisdom tooth-surgeries)? When? What kind of?

9. Do you take regular medication? What sort of?

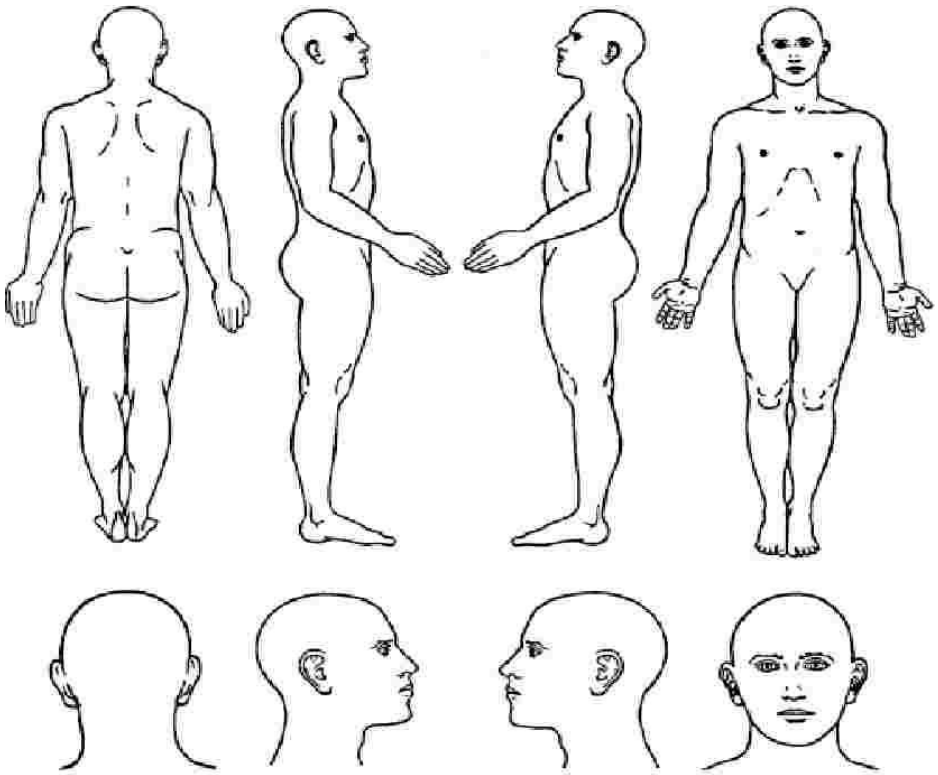
10. Are you regularly treated by a doctor (general practitioner, specialist doctors)?

11. Is there anything else important, what was not asked?

Actual problems

1. Which complaints led to consulting us?

Please draw on the sketch, where you have pain.



If your pain is from a certain area radiate forth (e.g. the neck), please mark this point with a cross (x); the direction of emission, they can mark with an arrow (•>).

2. When did the symptoms started, have there been a trigger? Did the pain / discomfort have changed over time, did it have migrated?

3. Do the symptoms change during the day?

4. In what posture (e.g. while sleeping, sitting, walking) complaints are they at their worst?

5. In what posture you have less or no problems?

6. What are the symptoms you have but pain (e.g. tingling, numbness, something is not working properly, dizziness, trouble sleeping, weight loss, etc.)?

7. Pain Quality: briefly describe their pain (e.g. acrid, burning, superficial, spasmodic, wavy, changeable, surrounding, drilling ...)

1. 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

2. Do you suffer from emotional stress (e.g. stress, conflicts, mourning ...)? Maintain / Supply a family member?

3. Have you had pre-treatments (injections, surgery, physiotherapy, straightening, spa ...)?

4. Did you have preliminary studies as specialist physician visits (e.g. neurological, internal medicine, urology, orthopaedic, gynaecological ...), X-ray, magnetic resonance imaging or similar? What result have been achieved?

5. What do you want to achieve (aim of the treatment).

Agreement

The examinations and treatments carried out in accordance with the Patients' Rights Act in accordance with recognized professional and therapeutic standards.

The duration of each treatment is performance-based 30 - 60 minutes. To this end, we allow ourselves a fee of 40 – 100 €to charge. The patient agrees to pay the fee for the service, regardless of whether an insurance this fully, partly or not responsible.
We are committed to adequately explain verbally the nature, scope, implementation and potential risks of the treatment.

Possible complications:
In general, our treatment measures with no side effects. When severe disturbances occur to you, inform your doctor!

Cancellation / cancellation fee agreement:
Agreed treatment appointments must be cancelled at least 24 hours in advance. Therefore, you can use our mailbox. If you miss your appointment or cancel with less than 24h notice, you will be charged with a cancellation fee of 50,00 €.

Noted:

_____ _____

(Place, date) (Signature patient)