

Questionnaire (anamnesis)

Please answer the following questions conscientiously to ensure that, on the one hand, no important diseases or physical limitations are overlooked and, on the other hand, our therapy can be even better tailored to you.

Family name/First name: _____

Date of birth: Day____ Month____ Year____ Age : _____

Address: _____ PLZ: _____

Phone number : _____ E-Mail: _____

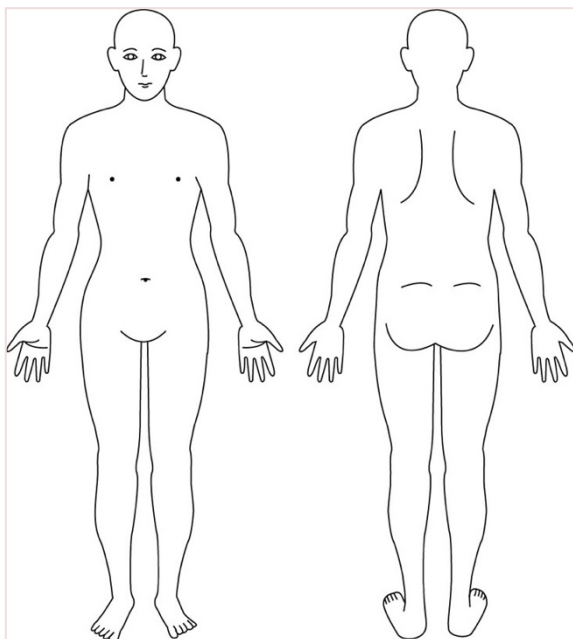
Start of treatment (date): _____

Health insurance : _____

Job: _____ (current occupational activity)

Reason for coming to this clinic: _____

Medical diagnoses, other therapies, medication, hospitalization:



More information about the symptoms:

Body part:

Intensity (1 - 10):

since when:

Quality:

Change:

Height: _____cm Weight: _____kg

Blood pressure/Pulse: _____ Body temperature: _____

Medical history (injuries/accidents/surgeries):

Vegetative anamnesis

(eating, drinking, micturition, stool, breathing or sleeping problems, etc.):

Gynecological history (pregnancies, births and menstrual disorders):

Psychosocial anamnesis :

Allergies: _____

Medication history:

(alcohol, tobacco, drugs, pills, psychotropic drugs, sleeping pills, food supplements, etc.)

specific infectious diseases (history; hepatitis, tuberculosis, HIV, etc.) :

Travel within Germany or stays abroad in the last 6 months :

Family history (cancer, asthma, neurodermatitis, mental illness, etc.):

Remarks and diagnosis(ICD10):

Emergency-suspicious physical manifestations and B-symptomatology