Praxis für natürliche Regenerations- und Heilverfahren

QUESTIONNAIRE

☐ **First Examination** ☐ **Acute treatment**

Please be as thorough as possible when answering the questions and if necessary consult immediate family members (parents, siblings, etc). Even illnesses you think are successfully treated and no longer pose a health issue may be meaningful towards proper diagnosis. For comprehensive treatment all mental and physical facts are important and may be relevant to and have an impact on your current state of health. The more information that is disclosed the less time will be required to diagnose the cause of your illness.

All data and patient information will be treated with confidentiality and will not be shared with third parties without prior consent.

FIRST NAME______________________LAST NAME ____________________________

Street no ____

Country __________ Postal Code _____________ City ___________________________

Phone / Mobile ____________________E-mail_____________________________________

Date of birth ________________ Family Status ______________ Blood type_________
Time of birth ________________ Number of Kids _____________ Risks _____________
Height _____________________
Weight ______________________ Current/previous employment_____________________

How did you hear about us? ____

Information about my Insurance / Instruction for Billing

O public ……………………………………………………………………………………

O governement aid...……………………………………………………………………..

O private ………………………………………… Ins-Nr ……………………………………..

O additional ……………………………………... Ins-Nr ……………………………………..

For billing we use “figures so called analog” according to the Gebührenverzeichnis für Heilpraktiker as long as our specification are not listed there.

We handle your Data carefully according to DSGVO

☐ I want to receive information by ☐e-mail ☐mail

1) What health problems/issues brought you to us? When did the first symptoms appear? (month/year, illness/diagnosis)

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____

____

2) List all accidents and surgeries. (month/year, diagnosis)

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3) List all prior childhood illnesses/diseases you have suffered from. (month/year/illness)

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4) List all vaccinations you had, approximate time of the vaccinations and if possible bring your vaccination
records with you. (month/year/vaccination)

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5) Do you have any allergies or any other intolerances/sensitivities? (month/year/diagnosis)

____

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____

6) What illness(es) do your parents suffer from or in case they are deceased, what was the cause of death? Please provide as much information as possible.

Mother

____

____

Living ☐ Deceased ☐

Year of death and Age: ____________

Cause of death:

Father

____

____

Living ☐ Deceased ☐

Year of death and Age: ____________

Cause of death:

7) FOR WOMEN - I had:

________ Number of births

________ Number of miscarriages

________ Number of abortions

I take birth control pills since ________

I carry a loop since ________

Nr. of hormone therapies ________

8) Which specialists have you consulted in regards to your current illness? Provide name of specialist, area of expertise, address. What specific tests/examinations have been preformed? Such as x-ray, MRI, CTscan, etc?

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9) List any therapy/treatments that you have received for your condition and when received. In case of treatments by psycho therapist/alternative practitioner/other list the type of treatment received and approximate date of treatment. For example: (month/year/type of specialist/treatment)

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10) List all medications that you take and duration. (month/year/drug/dosage)

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____

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11) Details regarding your lifestyle (check off what applies to you):

		Daily	Regularly	Occasional	Never
Do you smoke?		☐	☐	☐	☐
Do you drink:	Alcohol	☐	☐	☐	☐
	Coffee	☐	☐	☐	☐
	Black tea	☐	☐	☐	☐
	Coke/lemonade	☐	☐	☐	☐
Do you eat:	Sweets/Cakes	☐	☐	☐	☐
	Flour pastries	☐	☐	☐	☐
	Pork	☐	☐	☐	☐
	Sausage products	☐	☐	☐	☐
	Canned foods	☐	☐	☐	☐
	Overly salty foods	☐	☐	☐	☐
	Spicy foods	☐	☐	☐	☐
	Fruits	☐	☐	☐	☐
	Whole grain products	☐	☐	☐	☐
	Salads/raw vegetables	☐	☐	☐	☐
	Fresh vegetables	☐	☐	☐	☐
Do you sleep less than 6 hours?		☐	☐	☐	☐
Do you sit for more than 8 hours?		☐	☐	☐	☐
Do you watch more than 1 hours of TV daily?		☐	☐	☐	☐
Are you under stress?		☐	☐	☐	☐
Outdoor Activities?		☐	☐	☐	☐
What sports are you currently involved in?		☐	☐	☐	

12) Additional comments: use the space below for any information you want to share that you feel is important that was not covered previously in the questionnaire.

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What expectations do you have in regards to your examination/treatment with us? What would be the ideal goals that you would like to achieve?

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Statement:
I am aware that alternative practitioners claim their remuneration regardless of any reimbursements from health insurance companies. I am personally responsible for claiming any reimbursement of cost of treatment from my health insurance company.

Date: ____________________ Signature: _________________________________