



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

public

gouvernement aid.....

private Ins-Nr

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. Fee structure for our services:

1st time appointment/in-depth personal consultation/examination: 150 EUR

Ad-hoc acute treatment: 75-85 EUR

Follow-up examinations: 75-85 EUR

Additional drugs or applications are charged extra if required.

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)

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

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

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

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

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

Father

Living Deceased

Living Deceased

Year of death and Age: _____

Year of death and Age: _____

Cause of death: _____

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?

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)

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

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

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

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.

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?

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: _____