gans einfach gesünder

ilse gänsdorfer
heilpraktikerin | physiotherapeutin | osteopathin

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Medical history questionnaire

Last name: _____ First name: _____

Date of birth.: _____ Phone: _____

Street/No.: _____ Email: _____

Postal Code/City: _____ Occupation: _____

Height: _____ Weight: _____

GP/ relevant treating physician(s): _____

Health insurance: ☐ Statutory/public ☐ Privat Kasse: _____

Additional insurance covering alternative practitioner treatment: ☐ No ☐ Yes: _____

Dear Patient,
To provide you with the best possible and safest treatment, it is important that you inform me about your medical history and current symptoms. Your information will be treated confidentially and used solely for the purpose of your treatment. Please answer the following questions as completely as possible. If anything is unclear, we can discuss it during your appointment. If available, please bring any relevant medical reports, laboratory results, X-rays, CT or MRI reports/images with you. Thank you!

Date: _____ Main reason for your visit: _____

How long have you had these symptoms? _____

How did your symptoms start?

☐ suddenly ☐ gradually ☐ after an accident/injury ☐ no apparant cause

Do you experience these symptoms at night or at rest? ☐ No ☐ Yes

What have you already tried to relieve or treat your symptoms? e.g. medication, physiotherapy, massage, injections, exercises sports, etc.

_____

What do you expect or hope to achieve from my treatment?

_____

Do you take medications regularly or currently? (blood-thinning, corticosteroids, etc.) ☐ No ☐ Yes

If yes, please specify: _____

Do you take any dietry supplements? ☐ No ☐ Yes: _____

Are there any particular aspects of your diet? _____

♀ Are you currently pregnant or have you recently given birth? ☐ No ☐ Yes: _____

How would you rate your current stress level? (Please indicate your current stress level on the line below.)

no stress _____ maximum stress

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Medical History

Do you currently have, or have you previously had, any illnesses, surgery, or symptoms in the following areas? If yes please specify and, where relevant, indicate when.

Musculoskeletal system (e.g. pain, osteoporosis, fractures, slipped/herniated discs, joint replacements)

☐ No ☐ Yes:

Head/Nervous system (e.g. headaches, dizziness, visual disturbances, epilepsy, numbness/tingling, muscle weakness, problems with coordination)

☐ No ☐ Yes:

Jaw/Teeth (e.g. pain, teeth grinding/clenching, inflammation, major dental or jaw treatment)

☐ No ☐ Yes:

Respiratory system/Lungs (e.g. shortness of breath, cough/coughing up blood, asthma, frequent respiratory infections)

☐ No ☐ Yes:

Heart/Circulation/Blood vessel (e.g. high blood pressure, chest pain/tightness, abnormal heart rhythm/palpitations, vascular disease)

☐ No ☐ Yes:

Stomach /Bowel (e.g. nausea, pain, constipation/diarrhoea, blood or other changes in the stool)

☐ No ☐ Yes:

Metabolism (e.g. diabetes, thyroid disorder, unexplained weight loss, cancer)

☐ No ☐ Yes:

Kidneys/Bladder (e.g. pain, difficulty or pain when urinating, blood in the urine, recurrent bladder infections)

☐ No ☐ Yes:

Gynaecological/Hormonal (e.g. incontinence, menstrual problems, Caesarean section, altered sensation in the genital area)

☐ No ☐ Yes:

Immune system (e.g. fever, frequent infections, autoimmune disease, suppressed immune system, allergies)

☐ No ☐ Yes:

Mental health (e.g. depression, anxiety disorder, addiction/substance use disorder)

☐ No ☐ Yes:

Previous surgery, major accidents or injuries

☐ No ☐ Yes, which & when?

Sleep (e.g. night sweats, pain at night, unusual fatigue, sleep problems)

☐ No ☐ Yes: