Manual Care

PHYSIOTHERAPIE

PRIVATPRAXIS

Patient questionnaire

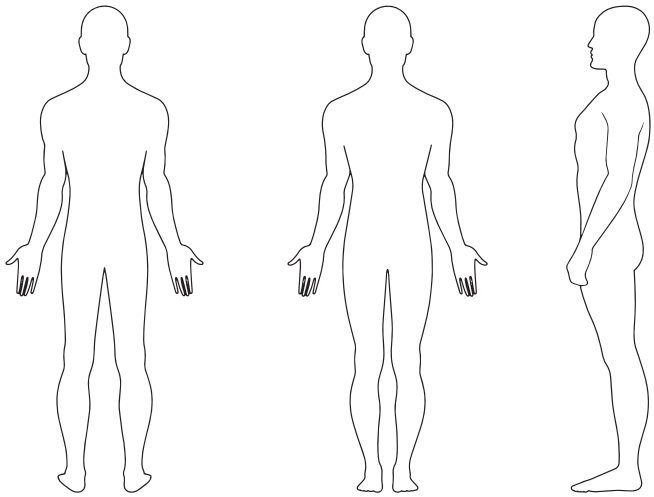
Dear patients,

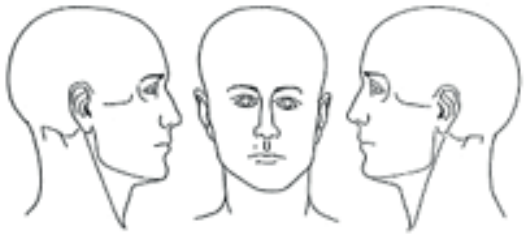
It is our goal to treat you optimally. For this we need some information about you and your complaints in advance.
All information is subject to confidentiality and will not be disclosed.

Name:	First Name:
Street:	ZIP code / city:
Date of Birth:	Email:
Phone Home:	Mobile:
Occupation:	Phone Work:
Household persons:	Marital status:
Children:	Sports / Hobbies:
Family doctor:	Prescribing doctor:
Health insurance:	☐ Privat ☐ Aid ☐ Self-payer

How did you hear about our practice?

1. **Where do you have problems (please draw in)?**





2. **Are you in pain?** ☐ No ☐ Yes

3. **How strong are your pains** *(circling)* **and maximal** *(please underline)***?**

No pain 0 1 2 3 4 5 6 7 8 9 10 maximum pain

4. **Are there any** ☐ painless phases ☐ painless postures?

If yes, which?

5. **Is your mobility changed?** ☐ No ☐ Yes

6. **Is your sensibility changed?** ☐ burning ☐ tingling ☐ numbness ☐ hypersensitivity

7. **Is your power changed?** ☐ weakness ☐ paralysis

8. **What are your main complaints in everyday life?**

9. **How long have you had your complaints?**

10. **Are you aware of a trigger for your complaints? (eg accident / fall / overload)** ☐ No ☐ Yes

If yes, which?

11. **What improves** *(circling)* **or what worsens** *(please underline)* **your complaints?**

activities calm lying sitting getting up from sitting bending standing walking running lifting carrying overhead work hand on back gripping work hobby sport

Morning, noon, evening, night, other

12. **Are your complaints:** ☐ getting better ☐ steady ☐ getting worse ☐ variable

13. **Do you suffer from:** ○ ☐ gait disorders ☐ balance disorders ☐ dizziness ☐ nausea ☐ fainting ☐ drowsiness ☐ dysphagia ☐ double vision

14. **Have you lost weight unexpectedly in the last few weeks?** ☐ No ☐ Yes

15. **Did you have:** ☐ fever ☐ extreme sweating at night in the last week?

16. **Do you have any other complaints?** ☐ No ☐ Yes

17. **Problems with:**
☐ coughing ☐ sneezing ☐ pressing ☐ inhalation
☐ blurred vision ☐ speech problems ☐ hearing problems
☐ incontinence ☐ constipation ☐ morning stiffness
☐ tendency to bruising ☐ shortness of breath ☐ cramps

18. **Over the last 2 weeks, my pain has been on a temporary basis.** ☐ No ☐ Yes

19. **Over the past 2 weeks, I've had pain elsewhere.** ☐ No ☐ Yes

If yes, where?

20. **Because of my pain, I only went short distances in the last 2 weeks.** ☐ No ☐ Yes

21. **During the last 2 weeks I have been dressing slower than usual because of the pain** ☐ No ☐ Yes

22. **For a person in my condition, it is really not advisable to be physically active.** ☐ No ☐ Yes

23. **I'm worried a lot in the last 2 weeks.** ☐ No ☐ Yes

24. **I feel that I am in terrible pain and that it is not getting better.** ☐ No ☐ Yes

25. **In general, I do not enjoy the things that I like doing otherwise.** ☐ No ☐ Yes

26. **Do you feel stressed at the moment?** ☐ No ☐ Yes

27. **Are or were you in psychotherapeutic treatment / coaching?** ☐ No ☐ Yes

28. **Is your sleep adequate and restful?** ☐ No ☐ Yes

29. **How disturbing was your pain seen in the last 2 weeks as a whole?**

☐ not at all ☐ low ☐ moderate ☐ strong ☐ extremely strong

30. **Does your pain have any of the following characteristics?**

☐ burning ☐ feeling of a painful cold ☐ electric shocks

31. **Do the following symptoms occur together with the pain in the same area of the body?**

☐ tingling ☐ pricking ☐ numbness ☐ itching

32. **What actions for diagnosis or therapy have been carried out so far?**

☐ X-ray ☐ Computed Tomography (CT) ☐ Magnetic Resonance Imaging (MRI)
☐ Injections ☐ Massage ☐ Physiotherapy ☐ Training
☐ Other .....

Did these actions help you? ☐ No ☐ Yes

33. **What goals do you want to achieve in therapy?**

34. **Are there any health risks or illnesses?** ☐ No ☐ Yes

If yes, which

35. **Do you currently take medication?** ☐ No ☐ Yes

If yes, which?

36. **Have you taken cortisone for a long time?** ☐ No ☐ Yes

37. **Have you taken any antibiotics (especially Levofloxacin) in the last 6 weeks?** ☐ No ☐ Yes

38. **What surgeries have been performed so far?**

In which year (approx.)?

39. **Have you ever had a** ☐ **tumor or** ☐ **cancer?**

40. **Do you have allergies or hypersensitivity to certain substances?** ☐ No ☐ Yes

If yes, which?

41. **Have you been diagnosed with osteoporosis?** ☐ No ☐ Yes

42. **Do you have** ☐ **very high or** ☐ **very low blood pressure?**

43. **Do you have coagulation disorders?** ☐ No ☐ Yes

44. **Do you have cardiovascular disease (such as angina pectoris, pacemakers)?** ☐ No ☐ Yes

If yes, which?

45. **Do you suffer from gout, rheumatism, asthma, diabetes or similar diseases?** ☐ No ☐ Yes

If yes, which one?

46. **Is there an organic disease?** ☐ No ☐ Yes

If yes, which?

47. **Do you have epileptiform seizures or cramps** ☐ No ☐ Yes

48. **Lo you suffer from infectious diseases?**
(such as hepatitis, tuberculosis, diphtheria, HIV, etc.) ☐ No ☐ Yes

If yes, which?

49. **Do you suffer from** ☐ **Migraine** ☐ **Headache?**

50. **Do you suffer from frequent infections?** (> 5 infections / year) ☐ No ☐ Yes

51. **Do you consume alcohol regularly** (more than 4 days / week) ☐ No ☐ Yes

52. **Do you smoke?** ☐ No ☐ Yes ..... cigarettes / day

53. **Are you pregnant?** ☐ No ☐ Yes If „yes" in which week? .....

54. **Do you breastfeed?** ☐ No ☐ Yes

I hereby confirm the correctness of my given data. I am aware that appointments must be cancelled at least 24 hours in advance, as otherwise an outage bill will be issued.

Date and signature .....

Thank you for answering the questions!