CHIROPRAKTIK OSTEOPATHIE
TIM KRÜGER

Dear Patient,

Please take a few minutes to fill out this medical history form.

Surname: _____ First Name: _____ DOB: _____

Address: _____ ZIP / City: _____

Phone: _____ Mobile: _____

E-mail: _____

Recommended by: _____

Health insurance: ☐ Statutory at _____ ☐ Private comprehensive at _____

☐ Private supplementary (alternative practitioners) at _____

(We do the billing according to *GebüH / Fees regulation* for alternative practitioners. Privately insured patients are normally compensated for the majority of their expenses. However, we cannot guarantee that your bill will be paid for by your health insurance provider.)

☐ Aided by: _____ ☐ Self-payer (cash payer)

Professional: ☐ I sit a lot ☐ I stand a lot ☐ Physical work

Sport: ☐ Not at all ☐ Occasional ☐ Regular ☐ A lot

Children: ☐ Yes ☐ No Age of children _____

I smoke: ☐ Yes ☐ No

Presently receiving medical treatment? ☐ No Yes ☐ Doctor ☐ Alternative practitioner

Name: _____

Current state of health

☐ I don't have any problems; I am here for preventative reasons.

I have considerable ailments in the range of:

☐ Lumbar spine ☐ Thoracic spine ☐ Cervical spine ☐ Head (e.g. headache, dizziness...)

☐ Joints _____ ☐ other _____

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☐ Acute symptoms since approx. _____ Days

☐ Chronical symptoms since _____ Weeks _____ Month _____ Years

My symptoms are ☐ Local Radiating up to? _____

My symptoms are ☐ Most intensive in the a.m. ☐ Getting worse in the course of the day
☐ Waking me up at night

Any causes? ☐ Car accident ☐ Fall ☐ Certain movement
☐ Other (prolonged sitting, "incorrect sleeping position", stress) _____

On a pain scale from 1 (no pain) to 10 (maximum pain), my symptoms are a _____

Are you taking any medicine?

☐ Pain medication ☐ Anti-inflammatory medication ☐ Cortisone
☐ Diabetes medication ☐ Cardiovascular drugs ☐ "Blood thinner"
☐ Other (antidepressants, pill…) _____

I am wearing insoles? ☐ Yes ☐ No

Medical History:

Any underlying diseases/ known illnesses? (e.g. Herniated disc, Cancer, Hypertension, Diabetes..)

☐ No ☐ Yes, which one(s)? _____

Serious disease(s) in your recent past? (e. g. infectious diseases, thrombosis…)

_____ When? _____

Any existing rheumatic symptoms?

☐ No ☐ Yes, which one(s)? _____

My parents / siblings suffer from the following diseases:

_____

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Any accidents / falls? ☐ No ☐ Yes, when/which? _____

Any surgeries? ☐ No ☐ Yes, where/when? _____

I have allergies? ☐ No ☐ Yes, which one(s)? _____

I have a digestive disorder? ☐ No ☐ Yes

I have scars? ☐ No ☐ Yes, where? _____

Teeth grinding at night? ☐ No ☐ Yes ☐ Don't know

I sleep on my tummy? ☐ No ☐ Yes

Pictures of my cervical spine have been taken already (X-Ray, CT-scan, MRI-scan) ☐ No ☐ Yes

Pictures of other areas are available ☐ Thoracic spine ☐ Lumbar spine ☐ Skull ☐ Other _____

Have you received any osteopathic or chiropractic treatment before?

☐ No ☐ Yes, last time _____ at _____

*Dear patient, to minimize waiting times, we reserve a time slot for you. We would like to point out that you will **not** be charged if you cancel your appointment **at least 24 hours beforehand**. In all other cases, **we are entitled to invoice you a handling fee**. If we can assign your appointment otherwise, we will of course **not** charge you for our downtime cost.*

Heidelberg, as of _____ Signature _____

Thank you for your cooperation!

Practice for American chiropractic and osteopathy Heidelberg

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