PRAXIS FÜR GESUNDES LEBEN

Case history – Questionnaire

Please take your time to fill in this questionnaire and take it with you for your upcoming appointment.

PERSONAL DETAILS

FIRST NAME

LAST NAME

STREET

NUMBER

ZIP CODE

CITY

LANDLINE PHONE

CELL PHONE

E-MAIL

DATE OF BIRTH

PLACE OF BIRTH

BODY WEIGHT / HEIGHT

INSURANCE STATUS (SATUTORY / PRIVATE)

PROFESSION

HOW DID YOU FIND OUT ABOUT US?

Praxis für gesundes Leben
Heilpraktiker Nedelmann und Doll
Kastanienallee 4, 10435 Berlin
Tel.: +49 (0)30 3198 5291
Fax: +49 (0)30 3198 5292
mail@praxisfuergesundesleben.de
www.praxisfuergesundesleben.de

SYMPTOMS

UNDER WHICH PHYSICAL AND MENTAL COMPLAINTS DO YOU SUFFER AND FOR HOW LONG?

☑ Prioritize your complaints from 1 - 8.

1.

2.

3.

4.

5.

6.

7.

8.

WHICH MEDICAL EXAMINATIONS HAVE BEEN ALREADY CONDUCTED?

HOW MANY DOCTORS, THERAPISTS AND NATUROPATHS HAVE YOU ALREADY CONSULTED?

DO YOU TAKE MEDICATION AND / OR SUPPLEMENTS? IF SO, PLEASE LIST BELOW.

IF SO, HOW SUCCESSFUL WAS THE MEDICAL TREATMENT?

☐ excellent ☐ good ☐ moderate ☐ poor ☐ extremely poor

WHAT HAPPENED JUST BEFORE THE OCCURENCE OF YOUR CURRENT SYMPTOMS?

☐ a disease ☐ distress ☐ grief ☐ shock ☐ surgery ☐ skin rash

☐ others:

WHICH TREATMENTS AGAINST YOUR COMPLAINTS HAVE YOU ALREADY REVEIVED?

WHAT DO YOU EXPECT FROM MY TREATMENT?

MEDICAL HISTORY

CHRONOLOGICAL MEDICAL HISTORY

☑ Please note previous diseases and surgeries you experienced in the past.

WHICH DISEASES APPEARED IN YOUR FAMILY?

- ☐ vascular diseases
- ☐ mental diseases
- ☐ proriasis
- ☐ veneral diseases
- ☐ cancer
- ☐ cardiac diseases
- ☐ diabetes
- ☐ hypertension
- ☐ multiple sclerosis
- ☐ urathritis
- ☐ neurodermatitis
- ☐ tuberculosis
- ☐ rheumatism
- ☐ stroke
- ☐ asthma
- ☐ allergies
- ☐ epilepsy
- ☐ others:

DO YOU HAVE SCARS FROM SURGERY?

☐ yes ☐ no

DO YOU OFTEN SUFFER FROM COMMON COLDS?

☐ yes ☐ no

PERFORMANCE

LACK OF CONCENTRATION?	☐ yes	☐ no	
TIREDNESS AND EXHAUSTION?	☐ yes	☐ no	
INCREASED IRRITABILITY	☐ yes	☐ no	
HOW RESILIENT AND POWERFUL ARE YOU FEELING?	☐ a lot	☐ moderate	☐ not at all

DIET

HOW MUCH DO YOU DRINK DAILY?

WHAT DO YOU USUALLY DRINK?

WHICH FOODS DO YOU EAT?

- ☐ dairy products
- ☐ nuts
- ☐ sugar
- ☐ white flour products
- ☐ sweets
- ☐ meat
- ☐ eggs
- ☐ cake
- ☐ fish

DIET

CRAVINGS FOR:

- ☐ sweet
- ☐ sour
- ☐ savory
- ☐ bitter
- ☐ salty
- ☐ spicy
- ☐ meat
- ☐ eggs
- ☐ fruits
- ☐ nicotin
- ☐ alcohol

AVERSION AGAINST:

- ☐ sweet
- ☐ sour
- ☐ savory
- ☐ bitter
- ☐ salty
- ☐ spicy
- ☐ meat
- ☐ eggs
- ☐ fat
- ☐ alcohol

FOOD ALLERGIES TO:

ARE YOU FOLLOWING CERTAIN DIETARY GUIDELINES?

☐ yes ☐ no

IF SO, WHICH?

HAVE YOU BEEN BREAST-FED? ☐ yes ☐ no

DID YOU GET A NATURAL BIRTH? ☐ yes ☐ no

ARE YOU WILLING TO IMPROVE YOUR EATING HABITS WITH OUR SUPPORT? ☐ yes ☐ no

APARTMENT

WHAT'S THE CONDITION OF YOUR LIVING SITUATION?

- ☐ nearby cell masts
- ☐ nearby transmission line / traction current
- ☐ nearby creeks / rivers
- ☐ mould infestation
- ☐ WIFI
- ☐ wireless phones / DECT
- ☐ microwave

DID YOUR APARTMENT GET INSPECTED ON ELECTROSMOG?

☐ yes ☐ no

HOW IS YOUR SLEEPING AREA EQUIPPED?

- ☐ bedside lamp
- ☐ electronic devices standby
- ☐ wires under the bed
- ☐ integrated electric motor

SLEEP

HOW IS YOUR SLEEP?

- ☐ struggle sleeping in
- ☐ frequent waking up at ________
- ☐ talking while sleeping
- ☐ night sweat

SLEEP

HOW IS YOUR SLEEP

- urination at night - how often: ______
- insomnia
- restless legs
- hot feet
- teeth grinding
- dream recall: yes / no

DO YOU FEEL LIKE GOING BACK TO SLEEP AROUND 10 OR 11 AM AFTER YOU WOKE UP?

- yes
- no

DO YOU FEEL ABLE STARTING THE DAY WITHOUT HAVING COFFEE?

- yes
- no

DO YOU (TRY TO) SLEEP BETWEEN 2 AND 4 AM?

- never / rarely
- sometimes
- always / often

ARE YOU LESS THAN 30 MIN AWAKE PER NIGHT? (INCLUDING FALLING ASLEEP AND WAKING UP)

- never / rarely
- sometimes
- always / often

ARE YOU SATISFIED WITH YOUR SLEEP?

- never / rarely
- sometimes
- always / often

DO YOU SLEEP BETWEEN 6 AND 8 HOURS PER NIGHT?

- never / rarely
- sometimes
- always / often

DO YOU STAY AWAKE DURING THE DAY WITHOUT NAPPING?

- never / rarely
- sometimes
- always / often

HEAD

DO YOU SUFFER FROM HEADACHES?

- never / rarely
- sometimes
- always / often

IN WHICH REGION DO YOU NOTICE THE HEADACHE?

- forehead / eyes / temples
- backhead
- one-sided: right / left
- double-sided
- moving from one side to the other

WHAT CAUSES THE HEADACHE?

______

WHAT IMPAIRS THE HEADACHE?

______

WHAT IMPROVES THE HEADACHE?

______

TEETH / JAW

- frequent visits at the dentist
- complaints during toothing

DENTAL FILLINGS

- amalgam
- gold

HEAD

TEETH / JAW

- ☐ difficulties of wisdom teeth to break through
- ☐ root canal treatments
- ☐ dead teeth
- ☐ sensitive teeth to: ☐ hot ☐ cold

DENTAL FILLINGS

- ☐ titanium
- ☐ synthetic materials
- ☐ ceramic
- ☐ palladium

HAVE THE AMALGAM FILLINGS BEEN REMOVED?

☐ yes ☐ no

HAIR

- ☐ hair loss ☐ circular ☐ sporadic
- ☐ since: ________

EYES

- ☐ conjunctivitis
- ☐ short-sighted
- ☐ long-sighted
- ☐ others
- ☐ eye glasses since:

____

EARS

- ☐ pain left
- ☐ pain right
- ☐ pain double-sided
- ☐ middle ear infection
- ☐ deafness
- ☐ tinnitus
- ☐ ear pressure

NOSE

- ☐ surgeries
- ☐ hay-fever
- ☐ allergies to

____

- ☐ discharges ☐ watery ☐ purulent ☐ mucous ☐ greenish
- ☐ obstructed nasal respiration
- ☐ blocked nose
- ☐ frequent nasal sinusitis

TONSILS

- ☐ frequent tonsilitis ☐ as a child ☐ today
- ☐ surgeries

THYROID

- ☐ hyperthyroidism
- ☐ hypothyroidism
- ☐ enlarged
- ☐ nodes
- ☐ surgeries
- ☐ others:

____

CHEST / ABDOMEN / BACK

BREAST GLAND

- [ ] complaints
- [ ] nodes
- [ ] surgeries

HEART

- [ ] complaints
- [ ] sharp pain
- [ ] pressure
- [ ] heart attack
- [ ] tightness
- [ ] rhythm disturbances
- [ ] hypertension

LUNGS

- [ ] bronchitis
- [ ] frequent coughing
- [ ] shortness of breath

LIVER

- [ ] inflammation
- [ ] hepatitis
- [ ] others: ______

GALL BLADDER

- [ ] stones
- [ ] colics
- [ ] surgeries
- [ ] pressure in the upper abdomen
- [ ] fat intolerance

STOMACH

- [ ] eructation / heartburn
- [ ] bloatedness
- [ ] gastritis
- [ ] lack of appetite
- [ ] food allergies

BACK

- [ ] pain
- [ ] lumbago
- [ ] tension
- [ ] herniated disc
- [ ] sciatica
- [ ] scoliosis

KIDNEY & BLADDER

- [ ] kidney stones
- [ ] inflammation
- [ ] frequency: ______

URINE

- [ ] often
- [ ] little
- [ ] normal
- [ ] can't control urination
- [ ] smells like: ______

INTESTINES

- [ ] infections
- [ ] haemmorhoides
- [ ] bloating
- [ ] appendectomies
- [ ] flatulence

BOWEL MOVEMENT

- [ ] daily
- [ ] every other day
- [ ] irregular
- [ ] smells like ______
- [ ] tendency to constipation
- [ ] tendency to diarrhea
- [ ] can't control defecation
- [ ] feeling of not getting finished

STOOL COLOR & CONSISTENCY

- [ ] light
- [ ] dark
- [ ] solid
- [ ] bulbous
- [ ] soft

ARMS

- [ ] injuries
- [ ] pain
- [ ] tennis elbow
- [ ] tingle
- [ ] cold hands

LEGS

- [ ] pain
- [ ] varicose veins
- [ ] surgeries
- [ ] injuries
- [ ] cold feet
- [ ] tingle
- [ ] numbness

SKIN & NAILS

- [ ] burn injuries
- [ ] scars
- [ ] itching
- [ ] warts
- [ ] fungi
- [ ] allergies to: ______

GYNECOLOGICAL / URULOGOCAL AREA

GYNECOLOGICAL - DISCHARGE

- [ ] none
- [ ] heavy
- [ ] white
- [ ] yellow
- [ ] acrid
- [ ] stains underwear

GYNECOLOGICAL - MENSES

When was your first menses? ______

When was the last menses? ______

bleedings are:

- [ ] light
- [ ] dark
- [ ] clumpy
- [ ] brown
- [ ] regular
- [ ] irregular

GYNECOLOGICAL - CONTRACEPTION

- [ ] birth-controll pill
- [ ] copper spiral
- [ ] hormonal spiral
- [ ] others: ______

GYNECOLOGICAL - OTHERS

- [ ] pain
- [ ] ovarian inflammation
- [ ] scraping
- [ ] miscarriage
- [ ] births: amount: ______
- [ ] abortion
- [ ] tumors
- [ ] cysts
- [ ] myomas
- [ ] veneral diseases

GYNECOLOGICAL / URULOGICAL AREA

URULOGICAL AREA

- [ ] prostate enlargement
- [ ] others: ______

SEXUALITY

- [ ] lowered
- [ ] increased
- [ ] normal
- [ ] complaints during intercourse

EMOTIONS

FEAR / FEELINGS OF GUILT / CONFLICTS — yes / no

DO YOU EXERCISE REGULARILY? — yes / no

HOW OFTEN DO YOU EXERCISE?

DO YOU SWEAT EASILY? — yes / no

DO YOU SWEAT AT NIGHT? — yes / no

IF SO, IN WHICH BODY AREA?

HOW DOES THE SWEAT FEEL — cold / warm

DO YOU FEEL COLD EASILY? — yes / no

cold hands / cold feet

DO YOU HAVE A PARTNER? — yes / no

HOW WOULD YOU DESCRIBE THE RELATIONSHIP TO YOUR PARTNER? — excellent / good / moderate / poor

HOW WOULD YOU DESCRIBE THE RELATIONSSHIP TO YOUR PARENTS? — excellent / good / moderate / poor

HOW HAPPY ARE YOU FROM 1 - 10?

1 not at all … 10 super happy

INFECTIONS

WHAT KIND OF INFECTIONS DID YOU EXPERIENCE?

- measles
- mumps
- rubella
- pertussis
- chicken pox
- tuberculosis
- syphilis
- scarlet
- tetanus
- polio
- malaria
- salmonellosis
- dysentery
- kissing disease
- gonorrhoea
- tropic diseases

HAVE THESE ILLNESSES BEEN TREATED WITH ANTIBIOTICS?

yes / no

IF SO, WHICH ONES HAVE BEEN USED?

VACCINATION

WHICH VACCINATIONS DID YOU RECEIVE?

- tuberculosis
- diphteria
- tetanus
- HIB
- pertussis
- polio
- measles
- mumps
- rubella
- cholera
- yellow fever
- hepatitis
- small pox
- influenca
- others:

DID YO EXPERIENCE REACTIONS TO VACCINATIONS?

- fever
- cramps
- restlessness
- insomnia
- behavioral changes

mediserv■

Hinweise für Patienten zur Abrechnung

Liebe Patientin, lieber Patient,

um mehr Zeit für Ihre Behandlung und Betreuung zu haben, halten wir unseren Verwaltungsaufwand so gering wie möglich. Deshalb haben wir die Abrechnung an unseren Partner übertragen:

mediserv Bank GmbH
66094 Saarbrücken

Für alle Fragen zur Abrechnung stehen Ihnen bei mediserv kompetente Ansprechpartner zur Verfügung.

Internet www.arztrechnung.de
E-Mail service@arztrechnung.de

Telefon 0681/4000789
Telefax 0681/400076

Die mediserv Bank GmbH unterliegt als Bank und Abrechnungsgesellschaft den einschlägigen Bestimmungen des Bundesdatenschutzgesetzes und verarbeitet Patientendaten mit höchster Sorgfalt und absoluter Vertraulichkeit.

Für dieses Abrechnungsverfahren benötigen wir Ihr schriftliches Einverständnis. Wir bitten Sie deshalb um Ihre Zustimmung durch Unterzeichnung der umseitigen Erklärung.

Vielen Dank für Ihr Vertrauen.

Ihre Praxis

Name und Vorname Patient: geb. am: Telefon:

Adresse Versicherungsstatus

Einverständniserklärung

Ich erkläre mich einverstanden mit der

- Weitergabe der zum Zwecke der Abrechnung und Geltendmachung jeweils erforderlichen Informationen, insbesondere Daten aus der Patientenkartei (Name, Geburtsdatum, Anschrift, Behandlungsdaten, Leistungsziffern, Beträge, Befunde) an die mediserv Bank GmbH;
- möglichen Einholung einer Information bei einer Auskunftei zur Prüfung meiner Zahlungsfähigkeit;
- Abtretung der sich aus der Behandlung ergebenden Forderungen an die mediserv Bank GmbH;
- sicherungsweisen Weiterabtretung der Forderungen durch die mediserv Bank GmbH einschließlich Weitergabe der zum Zwecke der Abrechnung und Geltendmachung an die mediserv Bank GmbH durch meine/n Heilpraktikerin/Heilpraktiker übermittelten Daten an die Bank 1 Saar, Saarbrücken.

Ich wurde darüber aufgeklärt, dass die mediserv Bank GmbH die Leistungen meiner Heilpraktikerin/ meines Heilpraktikers mir gegenüber im eigenen Namen in Rechnung stellen und für eigene Rechnung einziehen wird. Sollte es über die Berechtigung der Forderung unterschiedliche Auffassungen geben, kann mein/e Heilpraktiker/in in einer etwaigen Auseinandersetzung als Zeugin/Zeuge gehört werden.

Ich entbinde meine/n Heilpraktikerin/Heilpraktiker gegenüber der mediserv Bank GmbH sowie gegenüber den Beteiligten eines ggf. durchzuführenden Mahn- oder Streitverfahrens von ihrer/seiner Schweigepflicht, soweit dies für die Abrechnung und Geltendmachung der Forderungen erforderlich ist.

Meine Zustimmung gilt auch für zukünftige Behandlungen; ich kann diese jederzeit mit sofortiger Wirkung für die Zukunft widerrufen.

Ein Exemplar dieser Einverständniserklärung habe ich erhalten.

Ort, Datum

Unterschrift Patient bzw. gesetzlicher Vertreter

Gesetzlicher Vertreter:

Name, Vorname

Geburtsdatum

Adresse (falls abweichend)

Praxisstempel

EVE HP 10.14