CHIROPRACTIC
CENTER BERLIN

Questions about your person

Last Name: _____

First Name: _____

Address: _____

_____

E-mail: _____

Phone number: _____

Date of birth: _____

Marital status: ☐ single ☐ married ☐ divorced

Occupation _____

Type of activity: ☐ sitting ☐ standing ☐ physically

Type of health insurance? _____

Treatment will be paid by ☐ health insurance ☐ privately

Are you willing to change your lifestyle if necessary? ☐ yes ☐ no

How did you hear about us? _____

I assure you that these statements are true.

Date _____ Signature _____

Always remember - healing takes time!
Your body is able to perform amazing but healing is a process and it needs time and assistance!

Please describe your current complaints

_____

_____

_____

_____

Since when do you have these problems?

☐ for many years ☐ since a few months ☐ for weeks ☐ for days

Did you have these complaints before?

☐ No, this is the first time. ☐ Yes, more often. ☐ regular

How was the beginning? ☐ suddenly ☐ gradually

Have you been in treatment before?

☐ No

☐ Yes, at _____

Diagnosis _____

Therapies ☐ homeopathy ☐ acupuncture ☐ chiropractic ☐ massages

☐ Injection ☐ physiotherapy ☐ fango

☐ _____

Was it successful? ☐ very successful ☐ little successful ☐ no success

Are you taking any medication?

☐ No

☐ Voltaren ☐ Diclophenac ☐ Cortison ☐ Tramal ☐ _____

_____

How do the drugs work? ☐ good effect ☐ bad effect ☐short term

Did you have accidents or crashes in your life?

☐ No

☐ Yes, _____

Do you sleep well? ☐ No ☐ Yes

In which position do you sleep? _____

Do you wear insoles? ☐ No ☐ Yes, _____

Operations

☐ Appendix ☐ Tonsils ☐ Bile ☐ Band disc ☐ Hip

☐ Knee ☐ Subsoil ☐ Cancer ☐ Stomach/intestine

☐ _____

Did you have any of the following diseases?

☐ Osteoporosis ☐ Stroke ☐ Arthrosis ☐ Epilepsy

☐ Polio ☐ Arthritis ☐ Rheumatic fever ☐ m. Bechtrew

☐ Thyroid disease ☐ ms ☐ Cardiovascular disease ☐ Disc damage

☐ Diabetes ☐ _____

Which of the following complaints did you have in the last six months?

☐ Pain in the lower back ☐ stiffness ☐ jaw joint problems

☐ shoulder/arm pain ☐ neck pain ☐ Ischialgy

☐ Pain between the shoulders ☐ joint pain ☐ _____

☐ Breast pain ☐ swollen feet ☐ edema

☐ Blood pressure problems ☐ heart attack ☐ heart trouble

☐ Cardiac arrhythmia ☐ asthma ☐ varicose veins

☐ Problems with the lunge ☐ shortness of breath ☐ faints

☐ Dizziness

☐ Allergies _____

☐ Headache ☐ Migraine ☐ braces etc.

☐ Eye problems ☐ Caves ☐ Hardness of hearing

☐ Sore throat ☐ Ear pain ☐ Tinnitus

☐ Diarrhea ☐ nausea/vomit ☐ Liver trouble

☐ Hemorrhoids ☐ Appetite deficiency ☐ Stomach cramps

☐ Constipation ☐ Pallor complaints ☐ Weight problems

☐ Blisters complaints ☐ impotence ☐ prostatically

☐ discolored urine ☐ pain in water ☐ _____

☐ Irregular period ☐ PMS

Are you pregnant? ☐ No ☐ Yes, in the _____ month

What do you consume more or less regularly?

☐ Coffee ☐ Tea ☐ Alcohol ☐ Cigarettes ☐ Sugar

☐ Cannabis ☐ _____

Drinking quantity (non-alcoholic) per day: approx. _____ liter.