ADULT PATIENT QUESTIONNAIRE

marc james daly
OSTEOPATHIE & HEILKUNDE

Please complete before your appointment. You may type into the fields or print and write by hand.

YOUR DETAILS

Last name

First name

Street and number

Postcode and town

Date of birth (DD/MM/YYYY)

Occupation

Telephone

Mobile

Email address

Hobbies / interests

Sport / training

Preferred contact method

HEALTH INSURANCE

☐ Statutory ☐ Supplementary (Heilpraktiker) ☐ Private

☐ Beihilfe: yes ☐ Beihilfe: no

Statutory insurer (if applicable)

Supplementary / private insurer (if applicable)

Please check directly with your insurer which fees, if any, they reimburse.

YOUR CURRENT CONCERN

What is the main reason for your visit today? Please describe your symptoms and where you feel them.

When did your symptoms begin? Did they start after a particular event or develop gradually?

IMPORTANT SAFETY QUESTION

Since these symptoms began, have you had new bladder or bowel difficulties, numbness around the groin or bottom, or new or worsening weakness in either leg?

☐ Yes ☐ No

If yes, seek urgent medical assessment; do not wait for this appointment.

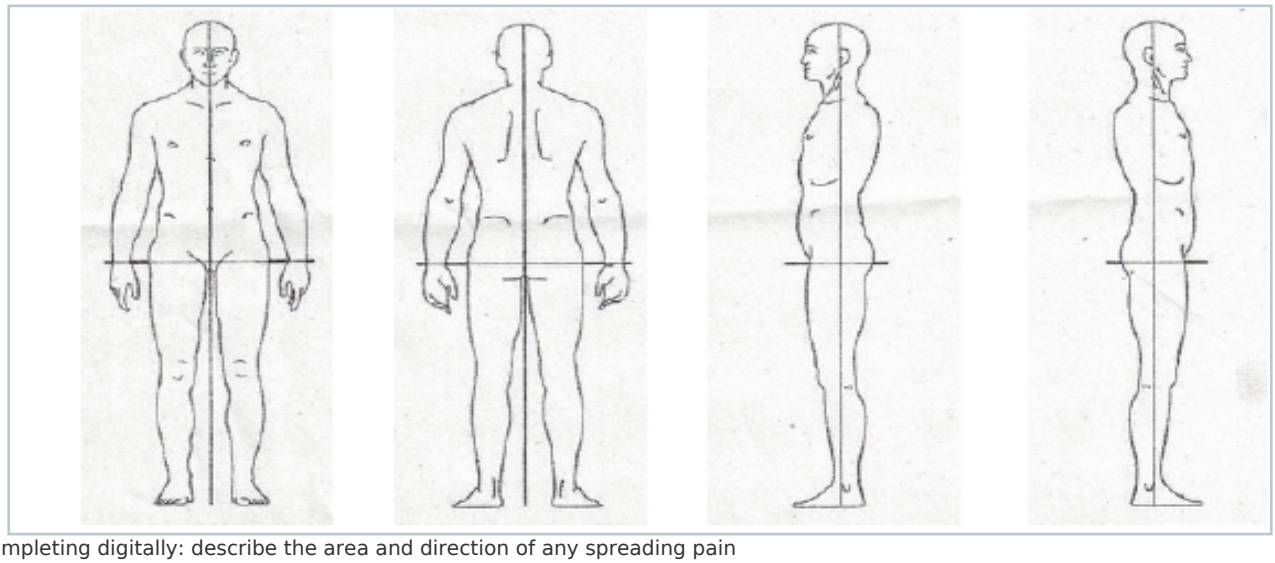
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Mark the body chart when printing; type a description when completing digitally.

LOCATION AND SPREAD OF SYMPTOMS

Mark the painful area and direction of spreading pain on the figures if printing.



If completing digitally: describe the area and direction of any spreading pain

WHICH ACTIVITIES OR SITUATIONS MAKE YOUR SYMPTOMS WORSE?

- ☐ Sitting
- ☐ Lying down
- ☐ Walking
- ☐ Straightening up
- ☐ Bending
- ☐ Turning
- ☐ Lifting
- ☐ Carrying
- ☐ Cold
- ☐ Heat
- ☐ Stress
- ☐ Coughing
- ☐ Physical exertion
- ☐ Prolonged standing
- ☐ Weather
- ☐ Bowel movement
- ☐ Urination
- ☐ Menstruation
- ☐ Gardening
- ☐ Sport / training

Other triggers / details

WHAT, IF ANYTHING, MAKES YOUR SYMPTOMS FEEL BETTER?

- ☐ Rest
- ☐ Sleep
- ☐ Movement
- ☐ Sport / training
- ☐ Stretching
- ☐ Heat
- ☐ Cold
- ☐ Pain medicine
- ☐ Massage
- ☐ Treatment
- ☐ Injections
- ☐ Other

Details

What would you most like to be able to do more comfortably after treatment?

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Symptom pattern - tick all that apply and add detail where useful.

PAIN AND TIMING

Pain today: 0 = no pain, 10 = worst imaginable pain

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Pulling ☐ Sharp / stabbing ☐ Pressure ☐ Burning
☐ Throbbing ☐ Tingling / crawling ☐ Dull ache ☐ Pulsating
☐ Constant ☐ Cramping ☐ Tearing ☐ Numbness
☐ Colicky ☐ Tightness ☐ Boring / deep ☐ Cold sensation

Other pain description

WHEN IS IT WORST?

☐ Morning ☐ Midday ☐ Evening ☐ Night
☐ Before / after food ☐ Before / after sport ☐ At work ☐ On getting up
☐ When seated ☐ At rest ☐ Constant ☐ Other

Pattern or other details

OTHER SYMPTOMS

☐ Skin redness ☐ Swelling ☐ Tender to touch ☐ Weight loss
☐ Weight gain ☐ Muscle weakness ☐ Restricted movement ☐ Vision changes
☐ Hearing changes ☐ Headache ☐ Fatigue ☐ Sleep problems
☐ Migraine ☐ Fever ☐ Chills ☐ Sweating
☐ Night sweats ☐ Paleness ☐ Unsteady walking ☐ Dizziness

Please explain any symptoms you ticked

TREATMENTS AND MEDICAL HISTORY

Have you sought help or had scans or tests for these symptoms? What were you told, and did treatment help?

Past illnesses, operations, chronic conditions, accidents, falls or injuries (with dates)

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Medical background - please give dates and details where you can.

FAMILY HISTORY

Known conditions in parents, grandparents or siblings - tick all that apply.

- ☐ Diabetes
- ☐ Asthma
- ☐ Kidney / gall stones
- ☐ High blood pressure
- ☐ Allergies
- ☐ Arthritis
- ☐ Gout
- ☐ Lung disease
- ☐ Vascular disease
- ☐ Depression
- ☐ Blood clots
- ☐ Stroke
- ☐ Multiple sclerosis
- ☐ Heart attack
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Liver disease
- ☐ Tumour / cancer
- ☐ Rheumatism
- ☐ Kidney disease
- ☐ Migraine / headaches

Other family history / details

MEDICINES AND OTHER HEALTH INFORMATION

Allergies or intolerances (include reactions if known)

Current medicines and supplements, with dose and frequency

If relevant: menstruation, pregnancy, childbirth or other information

Weight (kg)

Height (cm)

Blood pressure, if known

☐ I smoke ☐ I do not smoke

If yes: since when and how many cigarettes per day?

Activity level (0 = inactive; 10 = very active)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is there anything about your physical or emotional wellbeing that may affect your care?

Have you had an unwanted reaction to hands-on treatment, or is there an approach you prefer to avoid?

Anything else you would like us to know?