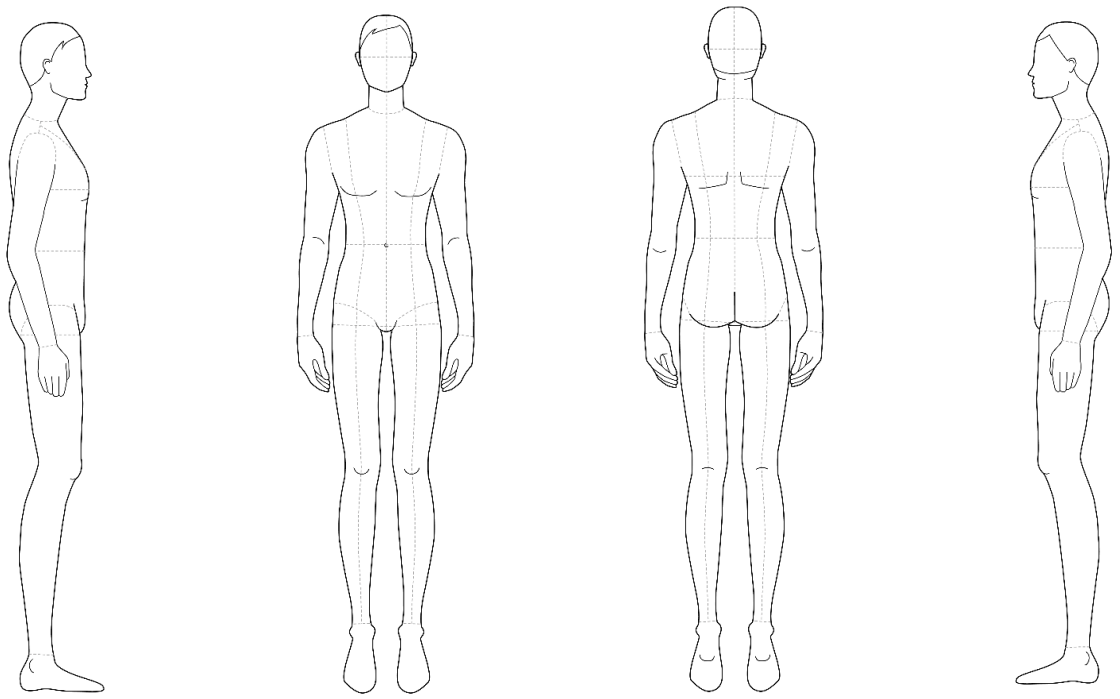
mediThera
praxis für physiotherapie & osteopathie

Dear patient,

To give you the best possible treatment is our goal. Therefore we need you to answer some questions about you and your condition beforehand. All personal information is subject to medical confidentiality and are treated with absolute discretion. Thank you for answering the questions!

1.) **Where** are your **complaints** located? (please draw in):



2.) What are your **main complaints**?

_____

3.) Do you have **pain**? yes ❑ no ❑

4.) Has your **mobility** changed? yes ❑ no ❑

5.) Has your **sensitivity** changed (*burning, tingling, numbness or hypersensitivity*)? yes ❑ no ❑

6.) Has your **strength** changed (*weakness or paralysis*)? yes ❑ no ❑

7.) What **troubles** you **in everyday life**?

_____

8.) **How long** have you been experiencing these **complaints**?

_____

9.) Has something **initiated** your complaints (*fall, accident etc.*)?

_____

10.) What **improves** your complaints (please circle your answer or write it down)?
Activity, rest, lying, sitting, raising from seat, bending forward, standing, walking, running, lifting, carrying, overhead work, gripping, working, hobby, sport, in the morning, at midday, in the evening, at night

_____

11.) What **worsens** your complaints (please circle your answer or write it down)?
Activity, rest, lying, sitting, raising from seat, bending forward, standing, walking, running, lifting, carrying, overhead work, gripping, working, hobby, sport, in the morning, at midday, in the evening, at night

_____

12.) How much **pain** do you have **at the moment**? (please circle your answer):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (maximum pain)

13.) How much **pain** did you have at **maximum**? (please circle your answer):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (maximum pain)

14.) Do you have your complaints (please circle your answer): **permanently/with interruptions**

15.) Are your complaints (please circle your answer): staying the **same**/getting **better**/getting **worse**

16.) Do you have pain at (please circle your answer): **coughing/sneezing/pressing/swallowing** yes ❑ no ❑

17.) Do you have difficulties with **walking/equilibrium**? yes ❑ no ❑

18.) Are you **pregnant**? yes ❑ no ❑

19.) Do you suffer from **headaches**? yes ❑ no ❑

20.) Do you suffer from **dizziness/nausea/fainting** or have you **difficulties at swallowing**? yes ❑ no ❑

21.) Are you a **diabetic**? yes ❑ no ❑

22.) Do you have **osteoporosis**? yes ❑ no ❑

23.) Do you have **additional medical issues** (e.g. *high blood pressure, fever, general discomfort etc.*)? yes ❑ no ❑

24.) Do you take **medication** at the moment? yes ❑ no ❑

25.) Have you ever had a **tumor** or **cancer**? yes ❑ no ❑

26.) Do you have **pain at night**? yes ❑ no ❑

27.) Have you **unintentionally lost weight** during the last weeks? yes ❑ no ❑

28.) Did you have **fever or night sweats** in the last weeks? yes ❑ no ❑

29.) Did you ever have had any **accidents or surgeries**? yes ❑ no ❑

30.) Do you have any **additional complaints,** which aren´t associated with your main complaints?
(such as problems with *vision, hearing, talking, continence etc.*) yes ❑ no ❑

31.) Are you afraid, that load/movement will **worsen** your **complaints**? yes ❑ no ❑

32.) Do you believe that your complaints will **persist in the long run**? yes ❑ no ❑

33.) Which diagnostic and therapeutic interventions have been carried out (please circle your answer)?

X-Ray / CT / MRT / injection / massages / physiotherapy / other:

_____
_____
_____
_____
_____
_____