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?

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## 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? 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 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 surgeries
- hypothyroidism others: _____
- enlarged
- nodes

## 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
- [ ] white
- [ ] acrid
- [ ] heavy
- [ ] yellow
- [ ] stains underwear

### GYNECOLOGICAL - MENSES

When was your first menses?

When was the last menses?

bleedings are:

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

### GYNECOLOGICAL - CONTRACEPTION

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

### GYNECOLOGICAL - OTHERS

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

## GYNECOLOGICAL / URULOGICAL AREA

### URULOGICAL AREA

- [ ] prostate enlargement
- [ ] others:

### SEXUALITY

- [ ] lowered
- [ ] normal
- [ ] increased
- [ ] 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 ☐ polio ☐ yellow fever

☐ diphteria ☐ measles ☐ hepatitis

☐ tetanus ☐ mumps ☐ small pox

☐ HIB ☐ rubella ☐ influenca

☐ pertussis ☐ cholera ☐ others:

DID YO EXPERIENCE REACTIONS TO VACCINATIONS?

☐ fever

☐ cramps

☐ restlessness

☐ insomnia

☐ behavioral changes