Anamnesis

Personal data:

last name: _____ first name: _____

date of birth.: ____/____/_____

street: _____zip code:_____city: _____

size: _____ weight: _____ ☐female ☐male profession: _____

telephone: _____ mobile: _____

e-mail: _____

health insurance: _____ ☐additional insurance

children: yes☐ no☐ name & of child/children: _____

In the case of under age people, please provide additional information about the legal guardian:
last name:_____ first name: _____date of birth:____/____/_____

Why is this form so important?
In our chiropractic clinic we focus on your personal health. The goal is to first look into the reason for your visit in more detail, and then to help you improve your health. Every day we experience physical, chemical or emotional stress, which can accumulate and be accompanied by a loss of health over a longer period of time without us being aware of it. Answering the following questions gives us a picture of your specific stress during your life and helps us to assess your health potential more accurately.

General information:

Type of activity: ☐ sitting ☐ standing ☐ physical work

How did you find out about our practice? _____

Have you ever been in chiropractic treatment? ☐ No ☐ Yes, last on ____/____/_____
at_____

Are you currently under medical treatment?

☐ No ☐ Yes, because of

_____

Please answer these questions to the best of your knowledge:

What significant diseases have you had in the last 5 years? Which chronical diseases do you suffer from?

_____

☐You have always been healthy

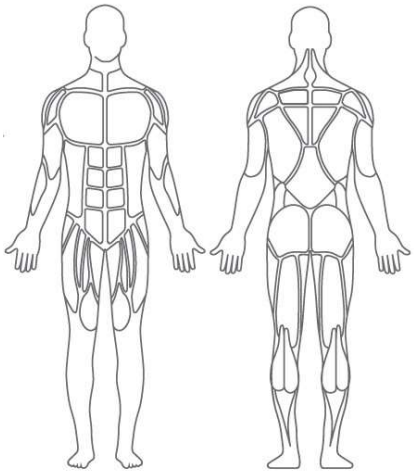
You have/had (where and when?)

Accidents/falls**:** _____
Operations**:** _____
Cancer diseases: _____
Allergies/intolerances: _____
Shoe insoles: ☐no ☐ yes, left ☐ yes, right ☐heel elevation ☐braces/retainers

Others: _____

Current state of health

☐ You have no complaints and are in practice for prevention.



Bitte markieren Sie Ihre Problemzonen

Why are you in our practice today?: _____

_____

How long have you had this problem?

☐ days ☐ weeks ☐ months ☐ years ☐ always

Since the problem has started, it is:

☐ the same ☐ better ☐ worse

The problem gets worse when:_____

_____

Problem gets better when:_____

_____

Your problem affects you when:

☐ working ☐ sleeping ☐ sitting ☐ running ☐ relaxing

Have you consulted other therapists about this problem? ☐ No ☐ Yes

Have preliminary examinations taken place? (X-ray, CT, MRT, orthopedist...): _____

Previous therapies used for this problem:_____

Here you will find yourself again:

☐ Headache	☐ Ear noises	☐ Blood pressure problems	☐ Joint problems
☐ Migraine	☐ Dizziness	☐ Stomach ulcers	☐ Shoulder pain
☐ Memory loss	☐ Nose bleeding	☐ Excessive sweating	☐ Back pain
☐ Drowsiness	☐ Jaw joint problems	☐ Weak immune system	☐ Muscular problems
☐ Fainting	☐ Sinus problems	☐ Bladder problems	☐ Change of eating habits
☐ Sensitivity to light	☐ Teeth problems	☐ Loss of appetite	☐ Change of intestinal transit
☐ Twitching eye	☐ Dead teeth	☐ Weight problems	☐ Skin problems
☐ Blurred vision	☐ Insomnia	☐ Digestion problems	☐ Whiplash
☐ Double vision	☐ Depression	☐ Heartburn	☐ Frequent blockades
☐ Visual impairment	☐ Fears	☐ Menstruation cramps	☐ Osteoporosis
☐ Imbalance	☐ Asthma	☐ Menopause symptoms	☐ Herpes, Epstein-Barr virus
☐ Taste impairment	☐ Shortness of breath	☐ Thyroid problems	

Every day life:

Hours of sleep: _____ hours./night Caffeine: _____ cups/day water/liquids: _____ l/day cigarettes: _____ /day alcohol: _____ glasses/week nutrition: ____ meals/day sports: ____ hours/week type of sport: _____ pregnancy: ____ weeks	On a scale of 1 - 6 (1=very good / 6= unsatisfactory) please describe your current condition: ___ sport / exercise ___ Drinking / Eating ___ Emotional balance / stress ___ relaxation / sleep On a scale of 1 - 6 please describe your stress level: (1=none / 6=extreme) ___ professional ___ privat

Dear Patient,

The diagnostic and therapeutic procedures performed in our practice are based exclusively on gentle Chiropractic techniques. However, we are legally obligated to inform you about the potential risks associated with chiropractic treatments. Below, you will find two relevant rulings by German courts. Please take amoment to read them carefully.

1. Ruling of the Higher Regional Court of Düsseldorf (dated 08.07.1993, case number 302/91)
"Patients must be informed about the potential risks of chiropractic treatments.
This ruling specifies that patients must be made aware of the rare risk that, despite correct manipulation of the cervical spine, permanent blood circulation disorders in the head may occur."

2. Ruling of the Higher Regional Court of Stuttgart (dated 20.02.1997, case number 14 U 44/96)
"A healthcare provider (doctor, naturopath, physiotherapist) cannot rely solely on informing the patient that their symptoms might worsen following the treatment. Instead, a patient with a pre-existing condition, such as a herniated disc, must be explicitly informed that, even with flawless execution of the procedure, there is a risk of disc material displacement, which could lead to spinal nerve root compression. This information is essential to ensure the patient's right to self-determination, particularly when the success of chiropractic therapy is uncertain and the healthcare provider is aware that the patient's goal is to avoid disc surgery."

A quick note about your insurance:
Payment is due after the treatment and can be made in cash or by card. Please check with your health insurance provider to see if you can arrange additional coverage that fully or partially covers the costs of naturopathic treatments. You will receive an invoice according to the GebüH (Prices plan for Heilpraktiker), which will be issued and handed to you after the treatment. If you have private or supplementary insurance, you can submit this invoice to your insurance company.
Thank you for your understanding and trust.

Consent Form:
I have been fully informed about the potential risks and side effects of the procedures performed and agree to undergo the treatment. If surgeries or treatments previously suggested by doctors are rejected or postponed, I acknowledge that this is done entirely at my own responsibility.

Furthermore, I agree to pay a cancellation fee of €25.00 if I fail to attend an agreed appointment without providing notice at least 24 hours in advance, either by phone or in writing.

I confirm that I am able to cover the costs of the treatment and the practice fee myself and acknowledge that I am the direct contractual partner responsible for payment to Chiropraxis – Praxisgemeinschaft M. Marzano and L. Geretti.

Additionally, I confirm the accuracy of the information I have provided.

Place, Date _____ , ____/____/_____ Signature _____

(For minors, please have the signature of a parent or legal guardian)

Data protection consent to the processing of personal data

I hereby give my consent to the processing of my health data in connection with my treatment in the Chiropraxis - Praxisgemeinschaft M. Marzano und L. Geretti.

I confirm:

- That the information required for proper information has been provided to me by the person in charge of the treatment before the data collection.
- That I have been informed that the processing of the data is necessary for the purpose of the medical treatment and on the basis of the underlying treatment contract.
- That I have also been informed that my consent covers the processing of sensitive data (health data) in accordance with Art. 9 of the DSGVO.
- My consent is given voluntarily. I am aware that I am not obliged to give this consent. If I do not give this consent, I will not suffer any disadvantages as a result. Without consent, however, no treatment can take place.
- I have taken note of the content of the printed cancellation policy before giving my consent.

For minors – I hereby grant _____ as legal guardian, my consent to the processing of health data in connection with the treatment of this child in the Chiropraxis -Praxisgemeinschaft M. Marzano und L. Geretti

Place, Date _____ , ____/____/_____ Signature _____

Cancellation policy

This consent can be revoked at any time and without giving reasons. The lawfulness of the processing carried out on the basis of the consent until the revocation is not affected by this. Statutory legal requirements remain unaffected by a revocation of the consent. In the event of revocation, continuation of the processing by the person responsible is generally no longer possible.
Consent can be revoked orally or in writing.