Naturheilpraxis Bieder-Laule

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Patient Questionnaire

Date: _____

Last Name: _____
First Name: _____
Birthday: _____
Home/Cell Phone: _____
Street Address: _____
Office phone: _____
City and Zip Code: _____
Fax: _____
E-mail: _____
Who referred you? _____
Family Doctor: _____
Doctor's phone number: _____
Private Insurance: _____
Profession: _____
If a student: School & Grade _____

Instructions:

1. Please fill out the questionnaire completely and bring to your appointment.
2. When there is an example provided, it is enough to underline the word. If other information applies, please include the specifics.
3. Please bring current medications, lab results and/or x-rays if available.

General Questions:

1. List your primary complaints and if you have a medical diagnosis.
Rate every complaint symptom from 1 to 10 (1 is very little, 10 is extremely strong) and indicate the month/year you started having the symptoms.

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2. Do you know what caused your symtpom(s) or what brought the symptons on?
e.g., pain, stress, diet, shock, grief, surgery, medication?

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3. Known diseases in your family history?
(Grandparents, parents, siblings and children)
e.g.: cancer, tuberculosis, depression, sexually transmitted disease, suicide, epilepsy, heartaches, angioplasty, stroke, asthma, diabetes, rheumatism, kidney-stones, gall-stones, multiple sclerosis, gout, allergies, psoriasis, neurodermitis, etc.

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4. What vaccinations have you received?
(Please bring you shot record if you are not sure.) e.g. : Tuberculosis (BCG), polio, diphtheria, tetanus, Haemophilus influenza (HIB), whooping cough, measles, mumps, rubella, hepatitis, cholera, yellow fever, Chicken pox (varicella vaccine), influenza, human papillomavirus (HPV), etc.

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5. Have you ever had a reaction to a vaccine, and if so, which vaccine?
e.g.: fever, spasm, restlessness, sleeplessness, change in behavior, etc.

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6. Have you had an infectious disease? Measles, mumps, rubella, whooping cough, chickenpox, shingles, scarlet fever, tetanus, polio, malaria, salmonella, dysentery, Pfeiffer's disease, Gonorrhoea, syphilis, tropical disease, tuberculosis, HPV, etc.

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7. Have you ever had any antibiotics or steroid treatments related to questions 1-6 above?

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8. Have you ever had problems with chemicals or metals? e.g., soaps, lead, solvents, etc.

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9. Do you have known allergies? Description:

Head

Head:

- Do you suffer from headaches? yes O no O
- How often, where and when?

_____

e.g., Seldom, forehead, eyes, temples, occipital region, one side, left, right, both sides, in the morning/evening, changing from left to right, from right to left, from behind to front

- Known cause of the headache: _____
- What makes it better? _____
- What makes it worse? _____

Hair: loss of hair, balding, bald spots, dandruff, and since when

_____

Eyes: conjunctivitis, cataract, near-sighted, far-sighted, macular degeneration, laser surgery, pink eye, etc.

_____

Ears: left, right, both sides, otitis media, difficulty of hearing, pain, sounds

_____

Teeth/Jaw:

Do you have a dentist	yes O	no O
Teething problems	yes O	no O
Wisdom teeth extraction	yes O	no O
Endodontic treatment	yes O	no O
Gingivitis bleeding	yes O	no O
Are there dead teeth	yes O	no O
Root Canal	yes O	no O
Sensitive to hot and/or cold	yes O	no O
Removing of amalgam	yes O	no O
Did you get an amalgam treatment	yes O	no O,

If yes, which tooth?_____

Your tooth filling material is, e.g., Amalgam, gold, plastic, ceramic, implantations

Nose: hay fever, handicapped breathing, blocked nose, watery secretion, mucous, green discharge, allergies, often paranasal sinusitis, polyps and/or surgery, what and when?

_____

Tonsils: operation, tonsillitis as a child or now, sore throat, bad breath

_____

Thyroid: hyperactive thyroid, hypo function, enlarged, operation

_____

Thorax / Abdomen

Mammary gland: pain, operation, node, cyst

Heart: aches, sharp pain, pressure, myocardial infarction, suffocating feeling, dysrhythmia, bypass

Blood pressure: your last test result

Lungs: bronchitis, coughing, sputum

Liver: inflammation, hepatitis, not holding liquor as well as in the past

Gall bladder: stones, colic, operation, pressure in upper abdomen, indigestibility of fat

Stomach: full feeling, gastritis, loss of appetite, food-allergies, heartburn

Intestine: infections, parasites, haemorrhoids, appendix operation, ulcers, gas: yes, no, smell

Bowel movement:

- **Frequency**: daily, 2/3/4 times a day, irregular, smell, constipation, diarrhea

- **Stool**: bright, dark, foul-smelling, hard, lumpy, soft, greasy, like a paste; bowel movement changing, needing a lot of paper or toilet-brush

Kidney/bladder: kidney stones, inflammation – often, sharp pain in the back – right, left

Urine: much, little, often, cannot hold, frothy, pain urinating, smells like

Arms / Legs / Back / Skin

Arms: pains, aches, tennis elbow, tingling, cold hands, etc.

Legs: pains, aches, varicose vain, operation, cold feet, tingling, feeling of numbness, open wounds

Back: tenseness, arthritis, aches, cervical-spine, thoracic spine, lumbar spine, lumbago, Ischia, Scoliosis

Skin/nails: ulcers, skin itching, wart, fungus, nail bed inflammations, eczema, skin-allergies, hives

Women

Gynecology: discharge – no, much, white, yellow, stains the underwear, open wound, pain, ovary-inflammation, womb-scrape, tumours, cysts, myome, yeast, venereal disease, etc.
Births/Miscarriages/Abortions: how many and year

_____,

_____,

_____

Menstruation:

- When was the first period: _____,
- the last time: _____
- Bleeding is bright, dark, lumpy, brown: _____
- How often, little, lasts long: _____
- Interval of the menses: _____
- Pain before- after – during the menses, which one: _____
- Bleeding in between: _____
- Menopause pain: _____
- Do you use contraceptives? Which one:_____
- Since when? _____

- When was your last gynecologist visit? _____

Men

Prostate: enlarged, have you had inflammations, acute pain, aches when urinating? Last cancer prevention screening?

_____

General Well-being

Do you have any scars? Including small scars. If yes, where and when did you get it?

_____

Sleep: sleeplessness, often awake at night (time:_____o'clock), difficulty falling asleep, talk in your sleep, restlessness in the legs, night sweat, hot feet, teeth-grinding

_____

Sleeping position: tummy, back, left, right, sitting, kneeing, fettle position

_____

Dreams: terrible, nice, in the mornings, thoughtful, realistic

_____

Fitness/Sports: _____

How often? _____

What is your fitness level now? (1=very good, 10= very bad) _____

Cravings:

- Likes: sweet, sour, spicy, salty, meat, eggs, fruits, nicotine, alcohol
- Dislikes: sweet, sour, spicy, salty, meat, eggs, fruits, nicotine, alcohol
- Indigestibility of_____
- Do you live in special guidelines? (Vegetarian, Gluten free, etc.?)

Smoke: yes O no O How much? _____

Alcohol: yes O no O How often? _____

What do you drink?_____

Drinking: How much fluids, exactly do you drink each day?_____liters.

House: Do you have electronics in your bedroom? _____

Are you using wireless or digital phones? _____

Pets: Do you have pet now? yes O no O _____

Have you ever had a pet? yes O no O _____

Have you had a therapy applied to you? e.g. oxygen, infusions, syringe, medications.

What's your opinion about your mental situation (1=very good, 10= very bad)

Itemize a chronology history of your illnesses and operations:

The Short Questionnaire

		yes	no
1	Tick-bite (scale tick, dog tick)		
2	Skin reddening at the place of the tick-bite		
3	Skin reddening at another place		
4	Joint/muscle-aches at the feet		
5	Swelling at the toes, at the ball of the foot		
6	Aches at the foot joint		
7	Burning in the feet		
8	Shin splints (aches in the front of the lower leg muscles)		
9	Not understandable fever, sweat, freeze		
10	Not understandable changing of weight (loss or increase)		
11	Fatigue, tiredness		
12	Not understandable hair loss		
13	Swollen lymph knot		
14	Sore throat		
15	Aches in the testicle / in the groin		
16	Understandable irregularity of the menstruation		

17	Understandable milk production (lactation)		
18	Sensitive bladder or bladder malfunction		
19	Sexual malfunction or loss of libido		
20	Stomach aches		
21	Changed stools habit (constipation, diarrhea)		
22	Aches in the chest and feeling wound over the ribs		
23	Short of breath, cough		
24	Palpitations, extra systole, bloc in cardiac regulation		
25	Joint aches or swelling		
26	Stiffness of the joints, the neck or the back		
27	Muscle hurt or cramp		
28	Itching in the face or other muscles		
29	Headache		
30	Crack or creak in the neck, neck stiffness		
31	Tickling, dumbness, burning or prick		
32	Face paralysis (Bell's Palsy)		
33	Eyes/eyesight: dubblesight, veilsight, aches, increased Mouches volantes(midge seeing)		
34	Ears/hearing: buzz, sounds, ear-aches		
35	Vertigo, imbalance, increased travel-disease		
36	Dazed feeling, confusion, difficulties when running		
37	Tremble		
38	confusion, difficulties when thinking		
39	Difficulties when concentrating or reading		
40	Forgetfulness, bad short-time-memory		
41	Disorientation: getting lost, go to the wrong places		
42	Difficulties when talking		
43	Change of mood, irritability, depression		
44	Disturbed sleep: to much, to less, awake early		
45	Increased symptoms or bad hangover after consumption of alcohol		
46	Heart- sounds(anamnestic), heart valve prolapsed in the past		