THERASPORT
Heidelberg

Date: ____. _____ _____

Medical history form

- Voluntary information, please fill in in advance -

Name: _____, _____ Date of birth (age): _____ (____)

Occupation/job: _____ Sport/hobbies: _____

Medical diagnosis: _____

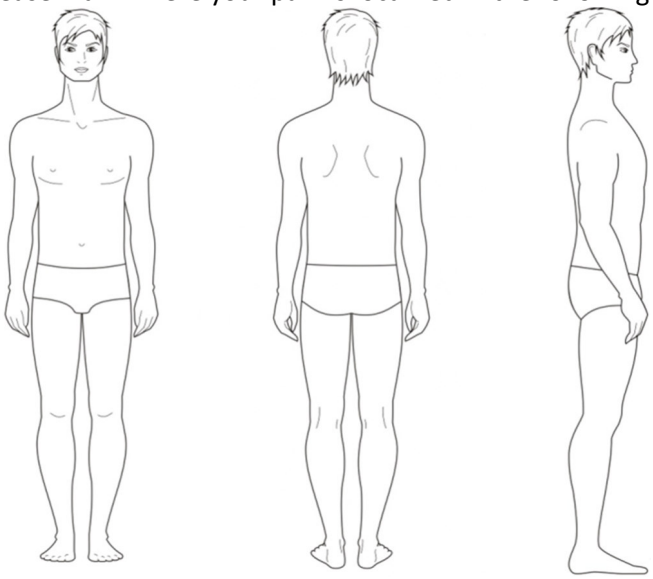
Please describe your chief complaint(s):

_____

Where is your pain localized and note the intensity?

_____

Please mark where your pain is localized in the following pictures and describe the symptoms.



When/during which activities do you have pain? (for example: at night, in the morning, pain on strain)

_____

Describe the quality of your symptoms? Please mark with a cycle.

pulled, prickly, burning, dull, radiating symptoms

Please mark a number:

Symptoms/pain intensity: none 1 2 3 4 5 6 7 8 9 10 hard

Since when did you have the described symptoms? Was there a trigger? if there was a trigger please note

_____

Please note any previous orthopedic/internal/nerval/psychic, … problems and related pain areas.

_____

Do you take any medication on a regular basis?
If so, please note what kind of (subgroups: pain, hypertension blood thinning, rheumatic, …) and the time of the intake.

_____

Did you have any previous operations? If so, please write down when and what kind of.

_____

_____

Do you have any other diseases, for example… (Please mark with a cross)

Dizziness/vertigo:	yes O	no O		
Tinnitus:	yes O	no O	left O	right O
Hypertonia:	yes O	no O		
Hypotonia:	yes O	no O		
Nausea:	yes O	no O		
Gastric upset:	yes O	no O		
Night sweat:	yes O	no O		
Unwanted weight loss	yes O	no O		
Frequent coughing:	yes O	no O		
Shortness of breath:	yes O	no O		
Osteoporosis:	yes O	no O		
Rheumatic diseases:	yes O	no O		
Diabetes:	yes O	no O		
HIV:	yes O	no O		
Cancer/malign disease:	yes O	no O	Name them:	_____
Hepatitis:	yes O	no O		
Allergies/Intolerances	yes O	no O	Name them:	_____

Others: _____

Note your recovery goals and expectations regarding the therapy

_____

Thanks a lot!

Below this, your therapists writes down further Informations

Beweglichkeit/Kraft/Sensibilität: _____

_____

_____

_____

_____

Geschichte: _____

_____

_____

_____

_____

_____

_____

_____

MRT/Röntgen: _____

_____

_____

Behandlungsplan: _____

The therapist informed me about the necessity, suitability, performing, goal(s), potential risk(s) and the extent of the treatment. This explanation is necessary due to the patient's bill of rights which is in force since 20 February 2013. I accept the regulation and agree to the following therapy.

Date: _____ Signature: _____