Your history

Dear patient,

In order to better understand your situation and to be able to offer you individual support, I would like to ask you to fill out the anamnesis form as completely as possible and to send it to me before the first appointment (preferably by e-mail or post). This is the best way for me to prepare for the appointment. All information will be treated with absolute confidentiality. If you can't or don't want to answer questions, leave the appropriate fields blank. We will then add to the questions in conversation. A partially completed form is also helpful. If necessary, also bring previous findings with you to the appointment.

Surname: First names: Date of birth:

Address / if different billing address:

Telephone / mobile number: Health insurance / or cash register:

Mail address: Family doctor:

Size: Weight:

Nationality:

What are your most important complaints at the moment?

I am already under medical treatment with this symptom ↓

_____ since: _____ yes no

_____ since: _____ yes no

_____ since: _____ yes no

_____ since: _____ yes no

_____ since: _____ yes no

_____ since: _____ yes no

_____ since: _____ yes no

Do you have a fantasy about what could have triggered the symptoms (a vaccination, an operation, a trauma, a grief or similar)?

_____

Are you being treated by a doctor, alternative practitioner, osteopath, physiotherapist or similar?

_____

How resilient and productive do you feel on a scale of 1 to 10 (1 = tired and exhausted / 10 = very good)

1 2 3 4 5 6 7 8 9 10

Do you suffer from illnesses, e.g.

1. of the cardiovascular system (e.g. high blood pressure)?
2. des Magen-Darm-Traktes?
3. of the respiratory tract?
4. of the joints (e.g. osteoarthritis / osteoporosis)?
5. of the thyroid gland?
6. of the nervous system?
7. of the kidneys or sexual organs?

Have you ever had a thrombosis? If so, was there a reason?

Have you had any surgeries?
If so: when, for what occasion and which parts of the body?

Have you ever had a malignant disease / radiation or chemotherapy?

Take medication, if so, which one (incl. dosage):

Do you tolerate medication well in general?

Do you take dietary supplements, if so, which ones?

Do you have intolerances or allergies (e.g. lactose, gluten, fruit or similar)?

Have you always tolerated vaccinations well or were there side effects?

Do you smoke or have you ever smoked? If so: by when / how much?

Have you been treated with antibiotics more often in the past?

Do you sweat particularly quickly? Do you sweat at night?

Do you exercise regularly? If so, what kind of sport?

Do you have scars or tattoos?

Do you drink alcohol regularly?

Do you tolerate red wine? Do you tolerate cheese? Do you tolerate fish?

Do you take drugs?

Have you ever taken advantage of cures or other preventive measures?

What else could be important about your background?

Family history

Have there been any diseases in the family, e.g. cardiovascular, diabetes, neurological diseases such as dementia, MS, Parkinson's disease, malformations or tumor diseases?

Gynaecological history (only for women)

How old were you when your menarche began?

Do you have regular periods?

Do you have intermenstrual bleeding or menstrual pain?

Do you have children, if so: born spontaneously or by caesarean section?

Have you had any miscarriages?

How old were you when your last menstrual period (menopause)?

Are you known to have fibroids, cysts or endometriosis?

Are you taking or have you taken the pill, do you have or have had an IUD?

Do you take other hormone-containing preparations, e.g. for menopausal symptoms?

Sleep	**yes or no**
I usually sleep more than 6 hours without interruption	
I often don't go to sleep until after midnight	
I usually get tired in the evening before 10 p.m.	
I'm having trouble falling asleep / staying asleep	
I have to go to the toilet at night (if so: how often?)	
I often dream vividly / I know that I snore or sleepwalk	
I in the morning and don't like to get up	

Sozialanamnese

What is your job?

Do you live in a relationship?

Do you have children?

Do you have any hobbies?

What housing conditions do you live in?

Psychological conditions

Have you noticed any of the following symptoms (please tick if necessary)?

1. Fatigue
2. Listlessness
3. Joylessness
4. Do you sometimes cry for no reason?
5. Lack of concentration / poor memory / do you often not come up with words?

1. Irritability
2. Fears (e.g. of height, darkness, confinement or open spaces, animals, people, dying)
3. Are you experiencing stress?
4. Can you relax well?
5. Do you have a circle of friends?
6. Are you religious/spiritual?
7. What role does sexuality play in your life?
8. Have there been any stresses recently (e.g. separations, deaths, conflicts)?

Nutritional history / lifestyle habits

What do you usually eat for breakfast / 1st meal:

2nd meal:

3. Meal:

How much do you drink every day? What do you mainly drink?

Are you vegetarian or vegan?

Do you eat a lot of fruit or vegetables?

Do you cook yourself or do you buy convenience products?

Do you eat a lot of meat?

Do you eat a lot of fish, mussels or other seafood?

Do you consume a lot of dairy products?

Do you eat a lot of rice?

Are there any foods that you cannot tolerate?

Do you have attacks of cravings for certain foods?

Do you often feel tired and exhausted after eating?

Do you fast regularly, e.g. intermittent fasting?

Do you follow any particular diets or dietary guidelines?

Are you prone to bloating or diarrhea?

How often do you have bowel movements?

Are you prone to acid regurgitation, upper abdominal discomfort or nausea?

Are you satisfied with your weight or would you like to gain or lose weight?

Do you have a pet or regular contact with animals (e.g. horses, dogs, cats, pigs, cows, sheep, birds, rodents, etc.)?

Have you already traveled to Africa, Asia or South America? If so, did you have a fever, diarrhea, or other symptoms during or during these trips?

Health of the oral cavity

Do you have dental fillings (amalgam, gold, plastic, ceramic)?

Do you have bridges or dead teeth?

Do you have periodontitis or periodontitis?

Possible toxin load

Do you have joint prostheses or other foreign materials in your body?

Do you regularly come into contact with potentially harmful substances (e.g. metals, wood preservatives, plasticizers, pesticides, microplastics, paints, tires, exhaust fumes, gasoline, etc.) at work, in your home or in your free time?

Electromagnetic radiation

Do you make a lot of calls with a mobile phone?

Do you often travel by plane?

Do you drive an electric car?

Do you track your sleep?

Do you have a cell phone near your bed at night?

Do you use a microwave or an induction stove?

Early childhood trauma

Early childhood trauma can have a lasting impact on a person's health! If questions are too personal, leave the fields blank.

Do you know whether your mother had psychological (e.g. depression) or social problems during pregnancy? Did she smoke, drink alcohol or eat poorly?

Have you had any of the following experiences in the first 3-4 years of life:

Corporal punishment, insults, degradation, neglect, sexual harassment, violence?

Were there mental illnesses, drug or alcohol consumption, separations, violence or the like in the family?

How would you describe your expectations of functional diagnostics and treatment?

Thank you for answering the questions and for trusting us to accompany you on your way to better health!

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