Physiotherapie Pfitzner

Dear patients,

This questionnaire serves as a supplement to the initial consultation with your therapist. It provides initial indications as to whether your symptoms can be effectively treated with physiotherapy or whether a more detailed medical examination is necessary, either beforehand or in addition to treatment. To this end, we require information about your health problem as well as your general health. Please try to answer all questions. If you cannot or do not wish to answer a question, mark it with a question mark. Any unanswered questions will be discussed during therapy.

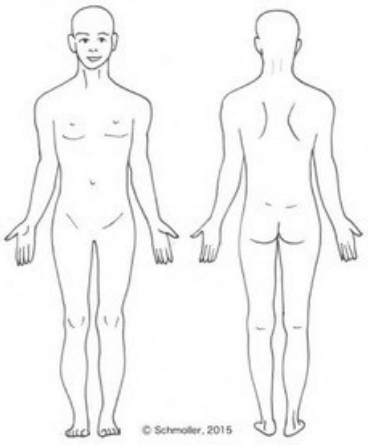
Your information is subject to confidentiality in accordance with Section 203 of the German Criminal Code (StGB).

Last name _____ First name _____ Birth of date _____

**Main health problem**

_____

**1** Please roughly mark the location and spread of the symptoms and describe them briefly:




_____

_____

_____

_____

_____

**2** Please indicate on the scale opposite your maximum pain level over the last 48 hours.

1 2 3 4 5 6 7 8 9 10

no pain worst pain

| | Yes | No | |
|---|---|---|---|
| **3** | ☐ | ☐ | Do you experience any of the following symptoms? |
| | | | Tingling Numbness Paralysis Spasticity |
| **4** | | | How long have you had these symptoms?: _____ |
| **5** | ☐ | ☐ | Have your symptoms worsened significantly in the last 2 weeks? |
| **6** | ☐ | ☐ | Are your symptoms caused by an event or injury? |
| | | | Brief description: _____ |
| **7** | ☐ | ☐ | Do you experience constant pain (no more than 10 minutes a day without pain)? |
| **8** | ☐ | ☐ | Do you also experience pain when resting? |
| **9** | ☐ | ☐ | Do you experience pain at night? |
| **10** | ☐ | ☐ | Are your symptoms dependent on movement and/or posture? |
| **11** | ☐ | ☐ | Is there a movement that you can no longer perform, e.g., leaning, standing, walking, straightening up? Which one? _____ |

**General state of health**

| | Yes | No | |
|---|---|---|---|
| 12 | | | Age: _____ Height: _____ cm Weight: _____ kg Gender: _____ |
| 13 | ☐ | ☐ | Have you lost weight unintentionally in recent months? |
| 14 | ☐ | ☐ | Do you currently feel generally unwell or ill? |
| 15 | ☐ | ☐ | Do you suffer from frequent infections? (more than 5 infections per year) |
| 16 | ☐ | ☐ | Do you suffer from visual disturbances, speech disorders, or swallowing difficulties? |
| 17 | ☐ | ☐ | Do you have persistent hoarseness or an unusual cough? |
| 18 | ☐ | ☐ | Do you have a high temperature, fever, or chills? |
| 19 | ☐ | ☐ | Do you suffer from night sweats? |
| 20 | ☐ | ☐ | Do you suffer from headaches? |
| 21 | ☐ | ☐ | Do you suffer from the following symptoms? Dizziness Nausea Vomiting |
| 22 | ☐ | ☐ | Do you have balance problems, gait disorders, or do you sometimes fall? |
| 23 | ☐ | ☐ | Are you under medical/therapeutic treatment? If so, why:_____ |

_____

**(Pre-existing) medical conditions**

| | Yes | No | |
|---|---|---|---|
| 24 | ☐ | ☐ | Have you been diagnosed with heart problems? |
| 25 | ☐ | ☐ | Do you experience chest pain during periods of physical exertion? |
| 26 | ☐ | ☐ | Are you generally less fit or do you get out of breath quickly? |
| 27 | ☐ | ☐ | Are you aware of any of the following conditions: |

☐ Diabetes ☐ Osteoporosis ☐ Tuberculosis ☐ Thyroid disorder
☐ Cancer ☐ Arteriosclerosis ☐ Organ disorders ☐ Blood clotting disorders
☐ Hepatitis ☐ HIV / AIDS ☐ Hormonal disorders ☐ Neurological disorders

Other: _____

28 ☐ ☐ Are you taking any medication or hormones?

| Reason for taking | Medication / Preparation | Since |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Continuation (pre-existing) conditions**

| | Yes | No | |
|---|---|---|---|
| 29 | ☐ | ☐ | Have you been taking cortisone for a long time? |
| 30 | ☐ | ☐ | Have you had any bone fractures and/or operations? |
| 31 | ☐ | ☐ | Do you consume alcohol, tobacco, or caffeine? Anything else? |
| 32 | ☐ | ☐ | Are you aware of any changes in your blood pressure? |
| 33 | ☐ | ☐ | Have you noticed any changes in yourself, such as memory problems, concentration difficulties, increased fatigue, or increased irritability? |
| 34 | ☐ | ☐ | Have you noticed any changes in your bladder and/or bowel control? |
| 35 | ☐ | ☐ | Do you experience sudden or progressive loss of strength in your arms or legs? |
| 36 | ☐ | ☐ | Have there been any cases of the following in your family: |

☐ Cancer ☐ Osteoporosis

☐ Heart disease ☐ Stroke ☐ Blood disorders

Is there anything else you would like to share in connection with your complaints?

## Explanation

Once you have read and understood all the questions and answered them to the best of your knowledge and belief, please confirm this with your signature!

Signature