FIT PRO QUO Physiotherapie ▪ Parcusstraße 8 ▪ 55116 Mainz ▪ www.fitproquo.de ▪ info@fitproquo.de ▪ 06131.49 48 36 0

Dear Patient,

we are pleased to welcome you to our practice.

It is our goal to treat you optimally. For that, we need some information about you in advance. All information is subject to confidentiality and will not be shared with third parties.

Name: _____

First name: _____

Health insurance: _____

date of birth: ____.____._____ Email: _____

Adress: _____ Phone: _____

_____ Mobile: _____

Occupation:_____ Sport/Hobby:_____

Referring doctor: _____

How did you hear about us? _____

If you are unable to attend an appointment, it must be canceled **at least 24 hours** before the scheduled time (by phone, voicemail, email, or contact form at www.fitproquo.de). If you do not cancel in time, we are required to charge you a cancellation fee according to § 615 BGB, regardless of the reason. The cancellation fee, depending on the appointment duration, is between €30 and €70. A replacement appointment can be arranged after the fee is paid.

Note for publicly insured patients: The legislator requires all publicly insured patients to make a co-payment when using therapeutic services (§ 61 SGB V). This is composed of: €10 per prescription + 10% of the treatment cost.

The co-payment is due at the beginning of the treatment and is made in the practice.

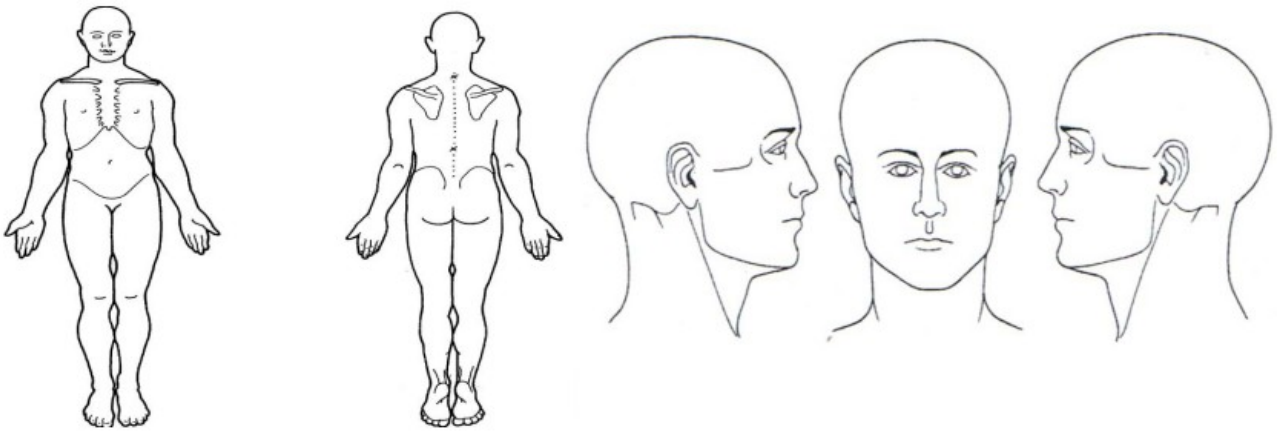
By signing, you confirm the accuracy of your information and acknowledge our cancellation fee policy.

You also consent that your data may be shared with the referring doctor, internal colleagues, or your health insurance for therapy-related decisions if necessary.

Datum:_____ Unterschrift: _____

To make your treatment as effective as possible, we kindly ask you to take a moment and answer a few questions about your current complaints and your health.

1.) **Where** do you have problems? (please mark) ?



2.) Do you have **pain**? yes □ no □

3.) Is your **mobility** changed? yes □ no □

4.) Has your sensation changed (burning, tingling, numbness, hypersensitivity, etc.)? yes □ no □

5.) Is your strength affected (weakness, paralysis)? yes □ no □

6.) What are your main complaints in everyday life? _____

7.) How long have you had these complaints? _____

8.) Do you experience your complaints-… **...permanent** □ ...**intermittent** □

9.) What **relieves** (*please circle*) or **intensifies** (*please underline*) your complaints?

Activity, rest, lying down, sitting, getting up from sitting, bending over, bending, standing, walking, running, lifting, carrying, overhead work, putting hand on the back, gripping, work, hobby, sport

Time of day: morning, midday, evening, night, other: _____

10.) **How intense** is your pain right now (*please circle*) and at its worst (*please underline*)?

No pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Maximum pain

11.) Are your complaints… **...improving** □ **...staying the same** □ **...worsening** □ ?

12.) Was there a **trigger** for your complaints (fall, accident, etc.)? yes □ no □
*Falls ja, welchen?*_____

13.) Do you suffer from **gait or balance issues, bladder weakness, dizziness, nausea, fainting spells, drowsiness, swallowing difficulties, or double vision**?
Please circle what applies yes □ no □

14.) Are you **asthmatic, diabetic**, do you have **osteoporosis** or... yes □ no □
...other conditions: _____

– turn around please –

15.) Are you currently taking any **medications** (e.g., cortisone, blood thinners, beta-blockers, etc. _____ yes □ no □

16.) Do you have **headaches**, **rest pain and/or nighttime pain**? yes □ no □

17.) Have you ever had a **tumor** or **cancer**? yes □ no □
If yes – when and where? _____

18.) Have you lost weight unexpectedly in recent weeks ? yes □ no □

19.) Have you had a fever, night sweats, or extreme sweating recently? yes □ no □

20.) Have you ever had **accidents and/or surgeries**? yes □ no □
*If yes – which?*_____

21.) Do you have any **other complaints**? *Please circle what applies*. yes □ no □

Vision-, speech-, hearing problems, incontinence, constipation, morning stiffness, tendency to bruising, shortness of breath, cramps, increased nighttime urination, etc.? ?

22.) In the last 2 weeks, my pain has sometimes **radiated**. yes □ no □

23.) In the last 2 weeks, I have had pain in **other areas**. yes □ no □

24.) In the last 2 weeks, I have walked **only short distances** due to pain. yes □ no □

25.) In the last 2 weeks, I have dressed **slower than usual** due to pain. yes □ no □

26.) It is really **not advisable** for someone in my condition **to be physically active.** yes □ no □

27.) In the last 2 weeks, I have often **worried**. yes □ no □

28.) I feel I am in **terrible pain**, and it is **not getting better.** yes □ no □

29.) In general, I have **not enjoyed** the things I usually like to do yes □ no □

30.) **How disruptive** have your pain levels been overall in the last 2 weeks? *Please check the appropriate box.*
Not at all □ little □ moderate □ strong □ extremely strong □

31.) Does your pain exhibit any of the following characteristics? *Please check what applies.*
burning □ sensation of painful cold □ elektric shocks □

32.) Do the following symptoms occur with the pain in the same area? *Please check what applies.*
timgling □ prickling □ numbness □ itching □

33.) What diagnostic or therapeutic measures have been taken so far? *Please check what applies* .
X-Ray □ CT □ MRI □ injections □ physiotherapy □ Training □
other: _____

34.) What are your expectations and goals for therapy?
_____

Thank you for answering the questions!