Health questionnaire

Physiopark
REGENSBURG

This questionnaire serves to ensure a safe physiotherapeutic treatment and rule out other reasons for complaints. It serves as the basis for a more detailed physiotherapeutic examination. Please try to answer all the questions. Open questions will be discussed in therapy.
Your details are subject to therapeutic con identiality.

Surname, first name .....

Date of birth .....

Do you have or have you had one or more of the following diseases?

		Yes	No
1	Diabetes mellitus	☐	☐
2	Gout	☐	☐
3	Rheumatic disease - if **yes,** which:	☐	☐
4	Osteoporosis	☐	☐
5	Tuberculosis	☐	☐
6	Have you ever been diagnosed with multidrug-resistant bacteria (MDR)?	☐	☐
7	HIV infection, AIDS illness	☐	☐
8	Hepatitis infection	☐	☐
9	Cardiovascular diseases - if **yes,** which:	☐	☐
10	Arteriosclerosis	☐	☐
11	Blood coagulation disorder (also drug influence)	☐	☐
12	Cancer	☐	☐
13	Neurological disorders	☐	☐
14	Hormonal disorders	☐	☐
15	Major operations - if **yes,** which:	☐	☐

		Yes	No
16	Do you **primarily** suffer from nocturnal pain?	☐	☐
17	Have you experienced unexplained weight loss in the last few weeks?	☐	☐
18	Have you been frequently diagnosed with bone fractures?	☐	☐
19	Do you frequently perspire at night?	☐	☐
20	Do you sometimes lose urine or stool involuntarily?	☐	☐
21	Do you suffer from paralysis, severe numbness?	☐	☐
22	Do you suffer from dizziness, unsteady walking, a tendency to fall?	☐	☐
23	Do you regularly take medication? If **yes,** which:	☐	☐
24	Are you pregnant?	☐	☐
25	Miscellaneous		

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