OSTEOCOMPACT-Praxis für Osteopathie

Osteopathic Medical History Adult: Date.....

Last Name: ..... First Name: ..... Date of Birth: .....

Postcode, City, Street, Address No.: .....

Phone Home ..... Phone (Mobil): .....

Email:.....

Health Insurance: ..... Occupation: .....

Family Doctor: ..... Orthopedist: ..... Dentist: .....

How did you hear about my practice? .....

What are your present symptoms?

On a scale from 1 to 10, evaluate your symptoms or impairment (10 being the most painful).

Symptoms	Since when	Severity
1.		
2.		
3.		
4.		

Briefly provide any relevant details of injuries due to accidents, heavy falls or punches (also in childhood) and/or caused following an operation.

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Are there any special circumstances or mental stress factor at your workplace?

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Was a clarification from medical perspective (orthopaedist, family doctor, etc.) successful in this regard? What kind of examinations did you undergo (laboratory, ultrasonic, x-ray, e.g.)?

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When was your last physical exam from your family doctor? .....

What treatment have you received so far regarding the above-mentioned symptoms (alternate or conventional medicine)? With what degree of success?

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Do you suffer or have suffered from any of the following disorders: heart, liver, pulmonary, kidney, blood pressure, diabetes, cancer, rheumatism, seizure, abdominal pain, migraine, etc.)

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Do you take medication? If any which one?

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Are allergies to drugs or food know? If any which one?

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Do you have dental problems? (e.g. dentures, one-side d chewing, grinding, clenching, temporomandibular joint pain, missing teeth, braces, crowns, implants, etc.)

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Do you ware day/night a bite splint or one specially made to measure for nights?

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Do you have any children? Yes (how many?) ..... No (not desired) .....

Were there any complications giving birth to your child/children? (caesarian section, forceps, etc.) .....

Were there any complications with your own birth?.....

Do you have painful or irritating scars on your body? .....

Do you suffer from sleep disorder? Yes ..... No ..... Sometimes .....

If yes, how many times do you wake up at night? ..... Night sweats? Yes ..... No .....

Do you suffer from digestive disorders, constipation, diarrhea, flatulency? .....

In your opinion, are you eating healthily? Yes ..... No ..... Occasionally .....

How much and what do you drink a day? .....

Do you exercise or make sport regularly after working hours?

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What do you expect from an osteopathic treatment?

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