Stefanie Albrecht – Heilpraktikerin Naturopath
Naturheilpraxis Albrecht

Date:

Health and Lifestyle questionnaire

Name:	Surname:
Street:	Postal code/City:
Phone:	mobile:
Occupation:	e-mail:
Date of birth:	Height / weight:
Marital status ☐ single ☐ married ☐ in relationship ☐ divorced ☐ widowed	Children: (sex and age) pregnant ☐ yes ☐ no if yes week:
Health insurance ☐ public ☐ private at:	Heilpraktiker supplementary insurance? at:
How did you find me? ☐ recommendation ☐ Instagram ☐ Project Ex-pats ☐ Google ☐ Google Maps ☐ other: ______________________________	

Experience with...	**Current stress level?**
☐ Yoga ☐ Progressive muscle relaxation ☐ Autogenic Training ☐ Meditation ☐ Massage ☐ Physiotherapy ☐ Craniosacral therapy/Osteopathy ☐ other:	0= relaxed; 10= extremely stressed |-----------------------------|-----------------------------| 0 1 2 3 4 5 6 7 8 9 10 since when? What could be the reason for this?

Main complaints why you are here and for how long have you had these?	**Intensity/ Pain 10= max.**	**Importance 10= max.**

Date:

What was going on before your current main complaints first appeared?

☐ Illness ☐ Grief/sadness ☐ Fright/shock ☐ Operation(s) ☐ Accident
☐ other:

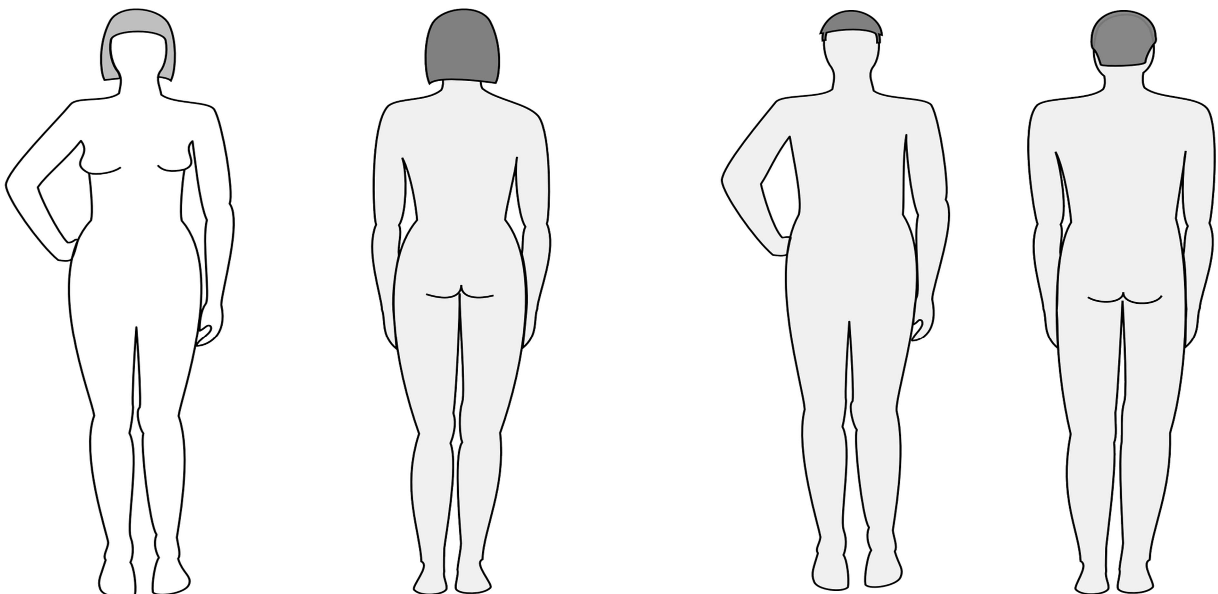
What medications, food supplements, etc. do you take regularly for what?	How often? i.e.. 3 daily	Dosage? i.e. 200 mg	Since when?

What surgeries, hospitalizations, falls, accidents have you had so far?	When/duration?

Is there any foreign material in your body? (Screws, pacemakers, stents, joint prostheses...)

Are there any scars on the body? If yes where?

Complaints:



Date:

Currently in treatment with physio-, psychotherapist, medical doctor for:	**since:**

Current infection or cold?

☐ No ☐ Yes, since?:

How often per year do you have colds?

☐ 1-3 ☐ more often

expresses itself with the following symptoms:

Diseases in your family

Illness	*Mother*	*Father*	*Grand-parents*	*Further*	*additinal information*
High blood pressure					
Low blood pressure					
Heart disease					
Lung diseases					
Vascular diseases					
Stroke					
Migraine					
Mononucleosis (Epstein-Barr-Virus)					
Gallstones					
Cancer (what kind?)					
Diabetes I					
Diabetes II (Adult-onset)					
Allergies					
Psoriasis					
Atopic dermatitis					
Alkoholism					
Depression					
Other mental illnesses (which ones?)					
Other					

Have you been treated for many diseases with antibiotics?

☐ no ☐ yes – How often in what period of time?

Have you been diagnosed with any chronic diseases so far? Which ones?

Head

Do you suffer from headaches?

☐ often ☐ rarely ☐ never
☐ cyclically at intervals of ____________________
☐ Forehead-eyes-temple region
☐ Occipital region

☐ mornings ☐ evening
☐ half-sided ☐ (more) left ☐ (more) right
☐ both sides ☐ Alternating sides

possible trigger(s):

Eyes

☐ complaints: ____
☐ Glasses since:

Teeth/ Jaw

☐ Dental surgery ☐ Root treated teeth
☐ Dead teeth ☐ Sensitive teeth to ☐ hot ☐ cold

Have you had amalgam fillings removed?
☐ yes ☐ no

Splint/night guard? ☐ no ☐ yes, since ________
☐ soft ☐ hard

Dental filling materials:
☐ Amalgam
☐ Gold
☐ Titanium
☐ Plastics
☐ Ceramics

Nose

☐ Operation(s): ____
☐ obstructed nasal breathing/nasal congestion
☐ often sinusitis

Tonsils/throat

☐ Operation ☐ often tonsillitis
☐ as a child ☐ today

Ears

☐ Pain left / right / both
☐ hearing impaired ☐ Ear sounds ☐ Ear pressure

Thyroid/vegetative

☐ Hyperfunction ☐ Hypofunction ☐ Enlargement ☐ Operation ☐ Knots

Do you sweat easily?
☐ no ☐ yes

Do you get cold easily?
☐ no ☐ yes
☐ cold hands ☐ cold feet

Menstruation

☐ regularly (every 28-30 days)
☐ irregularly, Spacing: _______________
☐ Mid-pain (ovulation noticeable)

☐ Cramps/pain
0= none; 10= extreme

Bleeding
☐ strong ☐ weak
☐ lumpy

Cyst/s
☐ one side ☐ both

Intermediate/smear bleedings
☐ before ☐ after regular bleeding ☐ mid-cycle
☐ no bleeding (menopause) since _________________

Digestion

Bowel movement
☐ daily _____ times
☐ every _________ days ____ times
☐ pain during defecation
☐ Bloating ☐ often air after eating

Consistency/appearance stool
☐ soft ☐ liquid ☐ clumpy ☐ hard
☐ sticky ☐ Food residues visible
☐ black ☐ white/bright ☐ bloody/Blood traces visible

Food Intolerances?:____

Date:

Lifestyle

How do you **work**? (Mehrfachauswahl möglich!)
☐ not employed ☐ ________ hrs/week Times: ____________
☐ employed ☐ self-employed ☐ Housewife/Mother ____________
☐ Shift work, since ______________ ____________

How do you **sleep**? ☐ np problems
☐ complaints:____
☐ falling asleep ☐ Difficulty sleeping through, since ______________ ☐ Awake at night
☐ Difficulties to wake up properly

☐ In the morning I feel tired/not refreshed: |--|--|
0= no tiredness; 10= extremely tired 0 1 2 3 4 5 6 7 8 9 10
since when? ________________________________
possible cause?: ____

☐ Fatigue lasts about consistently throughout the day
☐ During the day I get especially tired around __________ o'clock

How is your **sleeping place** set up?
☐ Radio alarm clock ☐ mobile phone/wireless phone ☐ electrical devices in standby mode (TV..?

Emotive

I know existential fears
0= not true at all; 10= is completely true
|------------------------------------|------------------------------------|
0 1 2 3 4 5 6 7 8 9 10

I have the feeling that I am needed
0= not true at all; 10= is completely true
|------------------------------------|------------------------------------|
0 1 2 3 4 5 6 7 8 9 10

I can achieve my goals
0= not true at all; 10= is completely true
|------------------------------------|------------------------------------|
0 1 2 3 4 5 6 7 8 9 10

I carry out regular leisure activities
0= not true at all; 10= is completely true
|------------------------------------|------------------------------------|
0 1 2 3 4 5 6 7 8 9 10

I feel my work is stressful
0= not true at all; 10= is completely true
|------------------------------------|------------------------------------|
0 1 2 3 4 5 6 7 8 9 10

I feel I can cope with life
0= not true at all; 10= is completely true
|------------------------------------|------------------------------------|
0 1 2 3 4 5 6 7 8 9 10

I can say NO
0= not true at all; 10= is completely true
|------------------------------------|------------------------------------|
0 1 2 3 4 5 6 7 8 9 10

I have friends/acquaintances
0= not true at all; 10= is completely true
|------------------------------------|------------------------------------|
0 1 2 3 4 5 6 7 8 9 10

How resilient and capable do you feel at the moment?
0= not at all ; 10= 100%
|------------------------------------|------------------------------------|
0 1 2 3 4 5 6 7 8 9 10

Have you been in psychotherapy?
☐ no ☐ yes, when?______________ for how long?________________________

Were/were there any events in your life that you feel were particularly serious/intrusive?
(Please only short bullet points if you want to share this in more detail at all. Yes or no is also sufficient.)

What do you expect from my treatment or what else is there to say?

I certify that the information I have provided is true and accurate to the best of my knowledge and belief, and that I have not withheld any important information that may hinder my recovery.

Signature

Date