Juliane Schmidt · Hauptstraße 8 · 27211 Bassum/Neubruchhausen

Juliane Schmidt
HEILPRAKTIKERIN

ANAMNESIS QUESTIONNAIRE

Please fill out the questionnaire in as much detail as possible in advance and bring it with you to our first appointment.

Thank you very much!

Surname _____

First name _____

Date of birth _____

Postcode, city _____

Street _____

Profession _____

Marital status _____

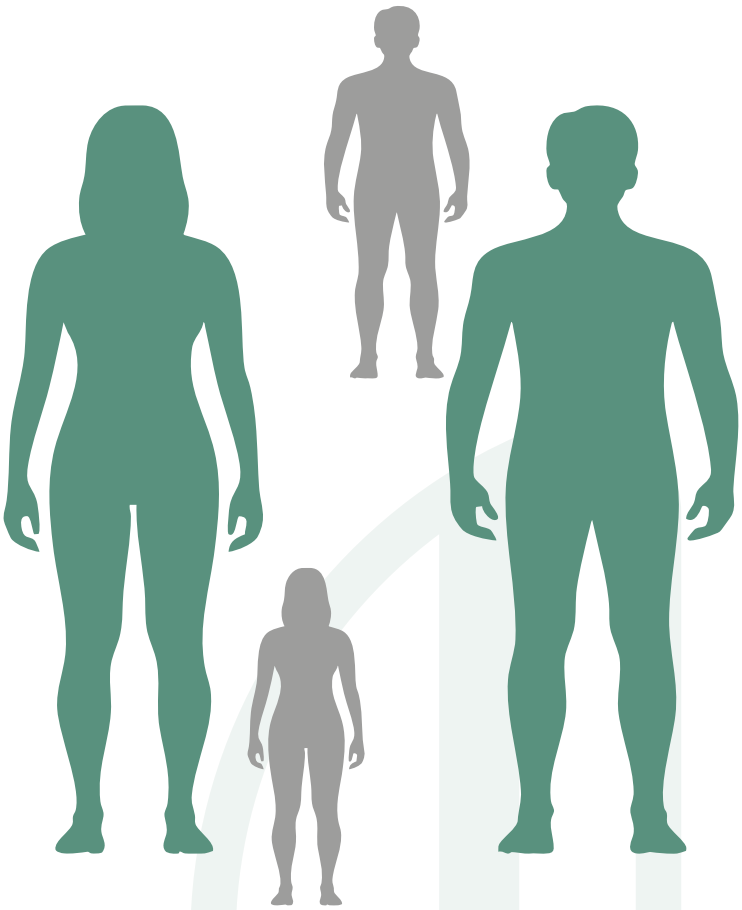
Telephone _____

Email _____

ACUTE COMPLAINTS

Where do you have acute complaints?

Simply mark intuitively.



What? (free description)

Where? (localisation)

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How? e.g. character of pain (bright stabbing or dull aching pain) and
Pain intensity (on a scale of 1-10)

When? Onset (since when? triggering factors), course (what improves, what worsens),
certain times of day

Why or what causes it? (triggering factors)

What treatments have you received so far? With what success?

OTHER ILLNESSES / OPERATIONS / TREATMENTS

(by doctors / alternative practitioners)

Disease / Operation / Treatment	Time / year	Does it exist?

What do you expect from my treatment?

TAKING MEDICATION	
What medication are you currently on?	

Do you take dietary supplements and if so, which ones and in what dosage?

FAMILY HISTORY	
Which diseases have more frequently occurred in the family (parents, grandparents, siblings)? (e.g. diabetes mellitus, cancer, cardiovascular diseases)	

SOCIAL ANAMNESIS	
What is your circle of friends like?	
What is your family like?	
What are your living conditions like?	
Are you exposed to particular stress at work?	
Are you exposed to certain harmful substances at work?	

GENERAL LIFESTYLE	
How much alcohol do you drink on average every day? What type of alcohol?	Quantity: Variety:
How many cigarettes do you smoke on average per day? At what age did you start smoking?	Cigarettes daily: since age:
Have you lost a lot of weight recently?	Yes ☐ Nein
Have you put on a lot of weight recently?	Yes Nein
Is your sleep restful? Do you suffer from difficulty falling asleep or sleeping through the night? If so, how long do you lie awake?	☐ Yes No ☐ Yes No
Are you very worried? Are you nervous?	☐ Yes No ☐ Yes No
Do you suffer from psychological problems, such as compulsions?	☐ Yes No
Are you noticeably thirsty?	☐ Yes No
Are you currently suffering from a fever or do you often suffer from a fever?	☐ Yes No

ALLERGIES	
Are you aware of any allergies to medication? Which ones?	☐ Yes No Which:
Do you have allergies or food intolerances to certain substances such as fish, eggs, milk, glutamate, lactose	☐ Yes No Which:
House dust allergies? Flower pollen? Others? Which ones?	Allergies to: Which:

Which foods do you eat or drink and how often?

(Cow) milk products	☐ never	rare	☐ daily	☐ several times a day
Sweets/ sugar	never	☐ rare	☐ daily	☐ several times a day
Soft drinks (cola)	☐ never	rare	☐ daily	☐ several times a day
Energy drinks	never	☐ rare	☐ daily	☐ several times a day
Coffee	☐ never	☐ rare	daily	☐ several times a day
White products	☐ never	☐ rare	daily	☐ several times a day
Wholemeal products	never	☐ rare	☐ daily	☐ several times a day
Pulses/ soya	☐ never	☐ rare	daily	☐ several times a day
Meat	never	☐ rare	☐ daily	☐ several times a day
Fish	never	☐ rare	☐ daily	☐ several times a day
Eggs	☐ never	☐ rare	☐ daily	several times a day
Vegetables	never	☐ rare	☐ daily	☐ several times a day
Fruit	never	☐ rare	☐ daily	☐ several times a day
Nuts	never	☐ rare	☐ daily	☐ several times a day

ALLERGIES		
Do you suffer from dizziness?	Yes	No
Fainting spells?	Yes	No
Epileptic seizures?	Yes	No
Headache?	Yes	No
Do you have problems with your eyes? Which ones?	Yes Which:	No
Do you have hearing problems?	Yes	☐ No
Earache?	Yes	No
Does a secretion sometimes flow out of the ear?	Yes	No
Do you have frequent or prolonged colds?	Yes	No
Do you have difficulty breathing through your nose?	Yes	No
Do you often suffer from nosebleeds?	Yes	No
Do you suffer from hair loss?	Yes	No
Do you have any particular complaints in the lip, mouth and jaw area?	☐ Yes Which:	☐ No

NECK AREA		
Do you have a sore throat or pain when swallowing?	Yes	No
LDo you suffer from a lumpy feeling in your throat?	Yes	No
Have you noticed an enlargement of the thyroid gland?	Yes	No
Do you suffer from hoarseness? For how long?	Yes	No

BREAST AREA		
Do you suffer from a cough? For how long? What is the nature of the sputum? Have you noticed blood in the sputum?	Yes How long? Condition: Yes	No No
Do you suffer from breathlessness?	Yes	No
Asthma-bronchial attacks?	Yes	No
Do you have a feeling of pressure or pain in the heart area?	Yes	No
Do you suffer from tachycardia or heart palpitations?	Yes	No
Do you (sometimes) have the feeling that food gets stuck in your oesophagus?	Yes	No
Do you suffer from back pain?	Yes	No

ABDOMINAL AREA		
Do you suffer from abdominal pain?	Yes	No
Do you have discomfort during or after eating? Which ones?	Yes Which one?	No
Do you have an intolerance to fatty, spicy or raw foods?	Yes	No
Have you recently noticed an aversion to meat?	Yes	No
Do you suffer from nausea or vomiting?	Yes	No
Heartburn?	Yes	No
Do you have problems passing stools, such as constipation, diarrhoea or pain?	Yes Complaint:	☐ No
Have you noticed any changes in the consistency, quantity or colour of the stool?	Yes Change:	No
Have you noticed blood in your stool?	Yes	☐ No

ARMS AND HANDS		
Do you have stiff or swollen joints?	JYes	No
Do your hands fall asleep (at night)?	Yes	No
Do you suffer from circulatory problems in your hands?	Yes	No
Do your hands (sometimes) tremble?	Yes	No
Do you (sometimes) have numbness in your arms or hands?	Yes	No

LEGS AND FEET		
Do you suffer from varicose veins?	Yes	No
Do calf cramps occur at night?	Yes	No
Pain in your legs or feet?	Yes	No
Do you have to stop after walking a certain distance due to pain?	Yes	No
Are your legs or feet sometimes swollen?	Yes	No
Pain in your hips, knees or ankles?	Yes	☐ No
Sensory disturbances in the legs or feet?	Yes	No

URINARY AND GENITAL ORGANS		
Do you have pain in the kidney area?	Yes	No
Pain when urinating?	Yes	No
Have there been any changes in urine volume or colour?	Yes Change:	No
Have you detected blood in your urine?	Yes	No
Do you have difficulty holding back urine voluntarily?	Yes	No
Have you noticed a weakening of the urinary stream?	Yes	No
Do you have to go out and urinate regularly at night?	Yes	No
Is there a secretion coming out of the urethra?	Yes	No

GYNAECOLOGICAL ANAMNESIS OF THE WOMAN		
At what age did the first menstrual period occur?		
When was your last menstrual period (menopause)?“		
How long is the cycle duration?		
How heavy is the bleeding? (weak, normal, strong)		
Do symptoms occur in connection with menstruation?	☐ Yes	No
Is there a secretion coming out of the vagina?	Yes	No
Do you have complaints in the breast area?	Yes	No

SKIN		
Do you suffer from skin changes?	Yes	No
Itchy skin?	Yes	No
Do bruises appear quickly in recent times?	Yes	No
Do your skin wounds heal badly?	Yes	No

Notes:

Date, signature _____