Achilles Altona Sport- und Physiotherapie
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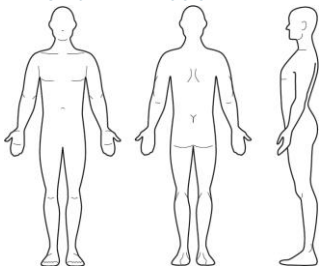
Voluntary disclosure for Patients

Dear Patient, in order to offer you the best possible treatment, we would be happy if you could provide us some extra information. Your data will only be used due to the separately GDPR-compliant agreement. Please be so kind to inform your physiotherapist actively, if your health condition is decreasing during the treatment period. Thank you for your help!

Your full name		**Date**	
Job		**Age**	

1. Where do you feel pain? (please draw in the body scheme)

front back



2.	Has your sensibility in terms of prickling or numbness changed lately?	☐ no ☐ yes
3.	Did you suffer any loss of power?	☐ no ☐ yes
4.	How long has the pain been lasting?	_____
5.	Did you experience a specific trigger or situation like an accident?	☐ no ☐ yes
6.	How strong is your pain currently on a scale from von 1 to 10?	Please encircle.
	no pain 0 1 2 3 4 5 6 7 8 9 10 maximal pain	
7.	Do you experience pain when coughing / sneezing /pressing / swallowing?	☐ no ☐ yes
8.	Do you suffer from high blood pressure or heart trouble?	☐ no ☐ yes
9.	Do you suffer from headache, swindle, vomiting or blackouts?	☐ no ☐ yes
10.	Do you have some of the following illnesses: Diabetes, Rheumatism or Osteoporosis?	☐ no ☐ yes
11.	Do you currently take any medicine?	☐ no ☐ yes
12.	Did you ever had a Tumor or any type of cancer?	☐ no ☐ yes
13.	Did you unwillingly lose any weight during the last weeks?	☐ no ☐ yes
14.	Did you suffer from feaver or nightly sweating in the last weeks?	☐ no ☐ yes
15.	Are you pregnant?	☐ no ☐ yes
16.	Which methods of diagnosis like X-ray / MRT or therapy like injections / physiotherapy or operation were performed so far?	Please encircle.

Please confirm with your signature that you have answered all questions truthfully.

_____ Signature