

Please fill in capital letters \* mandatory information

Mr. <input type="checkbox"/>	First Name*	Last Name*	
Ms. <input type="checkbox"/>			
Street*		ZIP code*	City*
Tel. Mobil*		Tel. Work	Birthday*
Tel. Privat*		Email*	
Referring doctor*		Address	
Health insurance* (basic insurance / Grundversicherung):			
Do you have supplementary insurance <input type="checkbox"/> Yes <input type="checkbox"/> No			
Copy of invoice per Email* <input type="checkbox"/> Yes <input type="checkbox"/> No <small>As of Feb 2022, all healthcare service providers are legally obliged to send their patients a copy of the invoice</small>			
Deductible (Franchise): <input type="checkbox"/> 300.- <input type="checkbox"/> 500.- <input type="checkbox"/> 1'000.- <input type="checkbox"/> 1'500.- <input type="checkbox"/> 2'000.- <input type="checkbox"/> 2'500.- <input type="checkbox"/> Child (under 18 years)			
How can we contact you?: <input type="checkbox"/> Landline, <input type="checkbox"/> Mobil, <input type="checkbox"/> Email, other:			

Only in case you had an **accident**, please fill in the following details:

Insurance company:	Date of accident:
Case number:	

How did you hear of us?

<input type="checkbox"/> Doctor	<input type="checkbox"/> recommendation (friend / family)	<input type="checkbox"/> Internet	other (please specify):
Where internet reviews important for you (i.e. Google reviews)? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> I don't know

### Declaration of consent

- to exchange medical data related to my treatment with the referring and treating physicians as well as medical officers of the funding agencies.
- if the bill for the treatment is not paid, to forward the necessary personal treatment data both to the billing institution and to the institution commissioned with any debt collection, as well as to the lawyer commissioned and to the competent state authorities.
- to create non-public lists of defaulters, which he/she may exchange with other physiotherapists.

**Appointments for treatment which I do not attend and which have not been cancelled at least 24 hours before the appointment will be invoiced to me privately (without entitlement to reimbursement by the health insurance company). I agree to cover all treatment costs that are not paid by my health insurance company/ KK,**

Swiss law is applicable.

Place, date

Signature of the patient

Please turn 

# EXTENDED FINDING QUESTIONNAIRE

In order to examine you thoroughly and specifically, we need some information from you. If a question is unclear, simply leave it out. All information is voluntary. We will look at them together later. Thank you very much!

Hobbies	Occupation
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Have you ever been diagnosed with any of the following conditions? Please mark with a cross.					
Covid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Long Covid	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what type?			
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what type?			
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Circulation problems	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Thromboses	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Gastric ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Kidney diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No			If so, what type?	
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Dependence on alcohol, medication, other substances	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Other inflammatory joint diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what type?			
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Seizure disorder, epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Urinary incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Other					
Have you felt down, hopeless, or depressed in the last month?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you been interested in and found pleasure in nothing for the past month?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been threatened hurt or intimidated by your partner or someone close to you?			<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please turn 

<b>Allergies:</b>	
Are you allergic to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, which ones?	
Are you sensitive to latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other allergies that may be important for treatment?	

<b>Are they receiving treatment from any of the following professionals?</b>			
Family doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatrist / Psychologist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteopath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physiotherapist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dentist	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chiropractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:			
Date of the last examination:			
Do you go to age-appropriate screenings?			<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last three months, have you been treated for any complaints by any of the professional groups listed above?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, which one was it about?			

<b>Please list all surgeries performed on you and each hospitalization with reason and approximate date:</b>
1.
2.
3.
4.
5.
6.

<b>Please list any serious injuries for which you required treatment (for example, broken bones, ligament injuries and the approximate date of injury:</b>	
Date	Injury

<b>Have any of your family members (parents, siblings) ever been treated for any of the following conditions? Please mark with a cross.</b>			
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependence (alcohol, drugs)	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inflammatory joint diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please turn 

Which of the following medications have you taken in the past week?			
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vitamins, minerals (food supplements)	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed
Paracetamol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herbal remedies	<input type="checkbox"/> Prescribed <input type="checkbox"/> Not prescribed
Ibuprofen, Diclofenac etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other, non-prescribed means:	
Medicines for stomach ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please list the medications you are currently taking as prescribed by your physician (pills, injections, medication patches, etc.):
1.
2.
3.
4.
5.
6.

Drinks and Tobacco	
How much coffee or other caffeinated beverages do you consume per day?	
How many cigarettes do you smoke per day? _____ For how many years?	
When did you quit smoking?	
How many days a week do you drink alcohol?	
How many glasses of beer, wine or similar do you drink on these days?	

Please check off current complaints that are new, unusual or atypical for you:			
Weight change	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint, muscle swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea, vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained hematomas (bruises)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heavy bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feeling of weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever, chills, sweating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Regular cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trembling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arm, leg swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
See double images	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of visual acuity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reddened eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation, diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in stool	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Climacteric, menopause	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexual function disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Impairments	<input type="checkbox"/> Yes <input type="checkbox"/> No	(possible) pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stress at work or at home	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

