Praxis Calandra
Physiotherapie & Naturheilkunde

# Patient Registration Form

physio swiss

Please fill in capital letters **mandatory information*

| | | | |
|---|---|---|---|
| Mr. ☐ Ms. ☐ | First Name* | Last Name* | |
| 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 ☐ Yes ☐ No | | | |
| Copy of invoice per Email* ☐ Yes ☐ No<br>As of Feb 2022, all healthcare service providers are legally obliged to send their patients a copy of the invoice | | | |
| Deductible (Franchise): ☐ 300.- ☐ 500.- ☐ 1'000.- ☐ 1'500.- ☐ 2'000.- ☐ 2'500.- ☐ Child (under 18 years) | | | |
| How can we contact you?: ☐ Landline, ☐ Mobil, ☐ 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?

| | | | |
|---|---|---|---|
| ☐ Doctor | ☐ recommnendation (friend / family) | ☐ Internet | other<br>(please specify): |
| Where internet reviews important for you (i.e. Google reviews)? ☐ Yes ☐ No<br>☐ 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 48 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 |
|---|---|
| | |

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

Please turn

| **Allergies:** | |
|---|---|
| Are you allergic to medications? | ☐Yes ☐No |
| If so, which ones? | |
| Are you sensitive to latex? | ☐Yes ☐No |
| Other allergies that may be important for treatment? | |

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

| **Please list all surgeries performed on you and each hospitalization with reason and approximate date:** |
|---|
| **1.** |
| **2.** |
| **3.** |
| **4.** |
| **5.** |
| **6.** |

| **Please list any serious injuries for which you required treatment (for example, broken bones, ligament injuries and the approximate date of injury:** | |
|---|---|
| Date | Injury |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| **Have any of your family members (parents, siblings) ever been treated for any of the following conditions? Please mark with a cross.** | | | |
|---|---|---|---|
| Diabetes | ☐Yes ☐No | Cancer | ☐Yes ☐No |
| Heart disease | ☐Yes ☐No | Dependence (alcohol, drugs) | ☐Yes ☐No |
| High blood pressure | ☐Yes ☐No | Depression | ☐Yes ☐No |
| Stroke | ☐Yes ☐No | Kidney diseases | ☐Yes ☐No |
| Inflammatory joint diseases | ☐Yes ☐No | | |

Please turn

| Which of the following medications have you taken in the past week? | | | |
|---|---|---|---|
| Aspirin | ☐Yes ☐No | Vitamins, minerals (food supplements) | ☐Prescribed ☐Not prescribed |
| Paracetamol | ☐Yes ☐No | Herbal remedies | ☐Prescribed ☐Not prescribed |
| Ibuprofen, Diclofenac etc. | ☐Yes ☐No | Other, non-prescribed means: | |
| Medicines for stomach ulcers | ☐Yes ☐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 | ☐Yes ☐No | Joint, muscle swelling | ☐Yes ☐No |
| Nausea, vomiting | ☐Yes ☐No | Unexplained hematomas (bruises) | ☐Yes ☐No |
| Fatigue | ☐Yes ☐No | Heavy bleeding | ☐Yes ☐No |
| Feeling of weakness | ☐Yes ☐No | Shortness of breath | ☐Yes ☐No |
| Fever, chills, sweating | ☐Yes ☐No | Regular cough | ☐Yes ☐No |
| Trembling | ☐Yes ☐No | Arm, leg swelling | ☐Yes ☐No |
| See double images | ☐Yes ☐No | Difficulty swallowing | ☐Yes ☐No |
| Loss of visual acuity | ☐Yes ☐No | Heartburn | ☐Yes ☐No |
| Reddened eyes | ☐Yes ☐No | Constipation, diarrhea | ☐Yes ☐No |
| Skin rash | ☐Yes ☐No | Blood in stool | ☐Yes ☐No |
| Sleep disorders | ☐Yes ☐No | Climacteric, menopause | ☐Yes ☐No |
| Sexual function disorders | ☐Yes ☐No | Problems with urination | ☐Yes ☐No |
| Night sweats | ☐Yes ☐No | Blood in urine | ☐Yes ☐No |
| Hearing Impairments | ☐Yes ☐No | (possible) pregnancy | ☐Yes ☐No |
| Stress at work or at home | ☐Yes ☐No | | ☐Yes ☐No |