Schöffner

Registration for Therapy

Our data protection regulations are available in the clinic or can be viewed on our website: https://www.schoeffner-physio.de

By clicking on consent, you confirm that we have informed you about this. You explicitly agree to the use of your data in our systems.

☐ **I hereby agree to the processing of my personal data.**

Consent can be revoked at any time. Revoking the consent does not affect the legality of the data processing carried out till then. Revocation can only be made in writing. Please note that in the event of revocation, the continuation of your treatment will not be possible.

Last name		First name	
Date of birth	TT.MM.JJJJ	Insurance	
Street & Number			
Postal Code		City	
Email		Phone	

How did you hear about our clinic? Please select an option, thank you!

☐ Internet ☐ Recommendation by a doctor ☐ Recommendation from relatives/ friends

Attention!

For sending invoices, medical reports, or other critical documents via email we use password protected PDF. Your personal password consists of your date of birth in the format DDMMYY

Important: In general, treatment is not possible if you feel sick and have fever!

General medical history

Age ☐ Height (m) ☐ Weight (kg) ☐

Do you have any underlying medical conditions? If yes, which ones? Please select.

☐ Diabetes	☐ Osteoporosis	☐ Hepatitis	☐ Autoimmune disease
☐ Cancer	☐ HIV	☐ Epilepsy	☐ Neurological disorder
☐ High blood pressure	☐ High blood lipids	☐ Long Covid	

Which medications, vitamins, and dietary supplements do you take regularly?

Have you had any surgeries? If, yes what kind of surgery and when?

Please select:

☐ Do you suffer from headache?

☐ Are you prone to infections?

☐ Have there been cases of cancer, osteoporosis, or heart disease in your family?

☐ Do you sometimes lose stool or urine when sneezing or coughing?

☐ **For women:** Are you pregnant? If yes in which week of pregnancy? ☐

Current Anamnesis

Is an accident the cause of your symptoms? If so, what kind of accident? Did you undergo surgery because of it? Do you have any lasting damage/ impairments?

Please describe your pain symptoms. What is hurting? What type of pain do you feel (e.g., stabbing, pulling, sharp, dull)? During which activities do you feel the pain? How long do you already suffer from the pain?

What helps to improve your symptoms?

Do medications help? If yes, which ones?

What examinations has your doctor performed?

Have you already undergone therapy for these symptoms?

Please send the completed document to schoeffner@physioprofi.de. Thank you very much!