Name:
First name:
Address:
Tel:
E-mail address:
Age:
Occupation:
Mutuality:
Who referred you to me :

What is the main complaint?

Do you have low back pain?
Do you have painful or tired knees?
Do you have pain in the neck?
Do you suffer from tinnitus or deafness?
Do you urinate frequently?
Do you have to get up at night to urinate?
Are there any sexual problems?
Do you often feel anxious?

Do you have palpitations?
How do you sleep (fast / wake up / early wake / bright dreams)?
Can you remember well-concentrate?

Do you generally feel too cold?
Do you have cold feet or cold hands or both?
Do you feel too warm in general?
Do you feel too hot at night?
Do you experience night sweats?
Do you leave your feet uncovered at night?
Do you have a thirst, do you drink a lot, do you need cold drinks?

Do you suffer from headache, how often?
Where is the headache located?
Do you feel irritable?
Do you get angry really fast?
Frequent or excessive sighing?
Do you have a bitter taste in the mouth?
Do you sometimes have a chest strain?
Do you feel depressed?

Do you suffer from burning, painful eyes?
Do you have a good vision?

Do you have a blurred vision in the evening?
Do you get out of bed easily?
Do you have brittle nails?
Do you have hair loss?
Do you have stiff muscles?
Do you experience feelings of dizziness?

Is the appetite normal?
How is the stool: too hard, too loose, alternate, real diarrhea, real constipation?
Do you have a lot of fatigue?
During the day, do you need to lay down frequently?
Do you suffer from stomach ache and / or acid reflux?
Do you suffer from a swollen feeling in the stomach?
Do your legs often feel lame, heavy?
Do you ruminate a lot?

Do you easily have bruises?
Do you easily have nasal bleeding?
Do you suffer from weaning?

Do you have painful joints?
Which joints especially?

Do you have colds easily?
Are you easily sick?
Spontaneous sweating for the least effort?
Are you easily sad?
Do you cough a lot?
Do you suffer from dry skin?
Or skin rashes?
If so:where on the body?
Itchy skin?

Do you take medication and / or do you have implanted electronics, if so which?
Did you have any surgery in the past?

Ladies only:
Is your cycle regular?
Is blood loss clotted?
Do you suffer from abdominal pain premenstrually?
Do you experience headache premenstrually?
Do you have swollen breasts premenstrually?
Do you suffer from infertility?

Nutritional habits:
Do you eat a lot of raw food, tropical fruit, sugar, cheese, meat, alcohol, fried food?

I, the undersigned, allow me to be treated freely.

I wish / don’t wish that / my doctor be consulted.

Signature,