

Dear patient,

It is our goal to treat you in the best way possible. In order to do this, we need some information in advance about your person and your complaints. The following questions relate to your main problem.

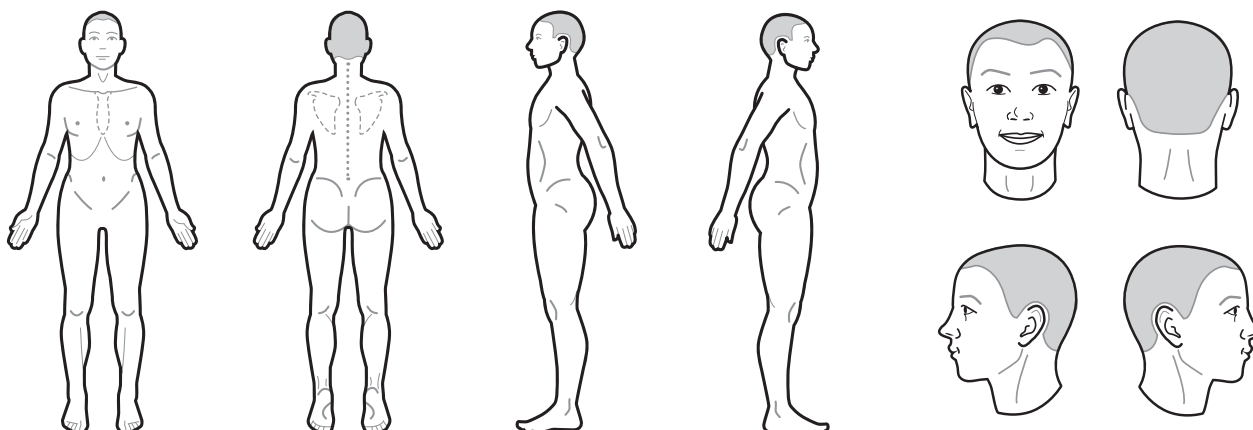
All information is subject to confidentiality and will not be passed on. Thank you for your trust!

Name: _____ Age: _____

Occupation: _____ Sport/Hobby: _____

Date, Signature: _____

1.) Where is the exact location of your physical complaints (please draw in)?



2.) Do you experience any pain? yes no

3.) Is your mobility changed yes no

4.) Is your sensitivity changed (burning, tingling, numbness, hypersensitivity, pins and needles)? yes no

5.) Is your strength changed (lack of strength, paralysis)? yes no

6.) What are your main complaints in everyday life? _____

7.) How long have you had your complaints? _____

8.) a) What improves your complaints? (please circle)

b) What makes your complaints worse? (please underline)

Activity, resting, lying down, sitting, standing up, bending, stooping, standing, walking, running, lifting, carrying, overhead work, reaching, work, hobby, sport, morning, noon, evening, other: _____

9.) How severe is your pain currently (please circle) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
(no pain) (maximum pain)

To answer questions 10-18, please consider the past two weeks only:

10.) How intense did your pain feel on average? (please circle) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
(no pain) (maximum pain)

11.) Are you often unsure how to deal with your pain appropriately? yes no

12.) Have you felt strongly disturbed by your pain in the past two weeks? yes no

13.) Have you been able to walk only short distances because of your pain? yes no

14.) Did you have bothersome joint or muscle pain in more than one part of your body? yes no

- 15.) Do you think your condition will last long? yes no
- 16.) Do you have any other significant health problems? yes no
- 17.) In the past two weeks, have you felt down or depressed because of your pain? yes no
- 18.) Do you think it is harmful for someone in your condition to be physically active? yes no
- 19.) Did you experience your current pain for 6 months or longer? yes no
- 20.) Does your pain exhibit any of the following characteristics?
 Burning sensation: yes no
 Feeling of painful cold: yes no
 Electric shocks: yes no
- 21.) Do the following complaints occur together with the pain you described and in the same area of your body?
 Tingling: yes no
 Pricking: yes no
 Numbness: yes no
 Itching: yes no
- 22.) Do you have your complaints: permanent/with interruptions (please circle)
- 23.) Are your complaints: getting better/staying the same/getting worse/variable? (please circle)
- 24.) Do you currently have resting/nighttime/continuous pain? (please circle) yes no
- 25.) Do you suffer from headaches, gait or balance problems, bladder weakness, dizziness, nausea, fainting spells, lightheadedness, fever, extreme night sweats, difficulty swallowing or double vision? (please circle) yes no
- 26.) Do you suffer from vision, speech, hearing problems, incontinence, constipation, morning stiffness, minor bruising, shortness of breath or cramping? (please circle) yes no
- 27.) Are you asthmatic, diabetic, have osteoporosis or other diseases? (please circle) yes no
- 28.) Are you currently taking any medications (cortisone, blood thinners, beta blockers, etc.)? yes no
- 29.) Have you ever had a tumor or cancer? yes no
- 30.) Have you unexpectedly lost weight in the last few weeks? yes no
- 31.) Have you had an accident/trauma/attack from a fall/surgery that could be related to your complaints? yes no
- 32.) Do you smoke? yes no
- 33.) How often do you exercise per week
 a) 150 minutes at low intensity (heart rate increased, talking is still possible)? yes no
 b) 75 minutes at higher intensity (heart rate increased, talking becomes impossible)? yes no
- 34.) Do you engage in strength training 2x a week? yes no
- 35.) Do you have difficulties falling asleep? yes no
- 36.) Are you able to sleep throughout the night? yes no
- 37.) Which diagnostic or therapeutic measures have been performed so far?
 x-ray/computed tomography(CT)/MRI/injection/massage/physiotherapy/exercise/other (please circle)
- 38.) What are your expectations and goals for therapy? _____

Therapist: _____