VfB Reha-Welt GmbH • Registration form

furchtlos und treu

Family name_____ First name_____

Date of birth_____ Health insurance_____

Adress_____ Zip code / city _____

T.privat_____ T.business_____

T.mobil_____ email _____

Please notice arranged appointment have to be canceled at least 24 hours before the therapy. In the event of non-compliance with the agreed dates or if appointments are not canceled in time, we will have to bill you privately for the value of the canceled treatment.

Any charges oft the prescription should be paid at your second appointment. Please ask us about the amount of charge.

- O Please mark, if you are exempt payment

Only for private patient

- O Please mark, if you are a private patient

I hereby declare to accept the valid and posted rates. The individual rates can partly be higher than the mount refunded by your health insurance; it won't your invoice

By submitting the form, the personal data you provide will be collected by us. For the data protection treatment of the information provided by you, we also refer to our privacy policy, which is available at www.vfb.de/datenschutz. Upon request, a privacy policy will be provided.

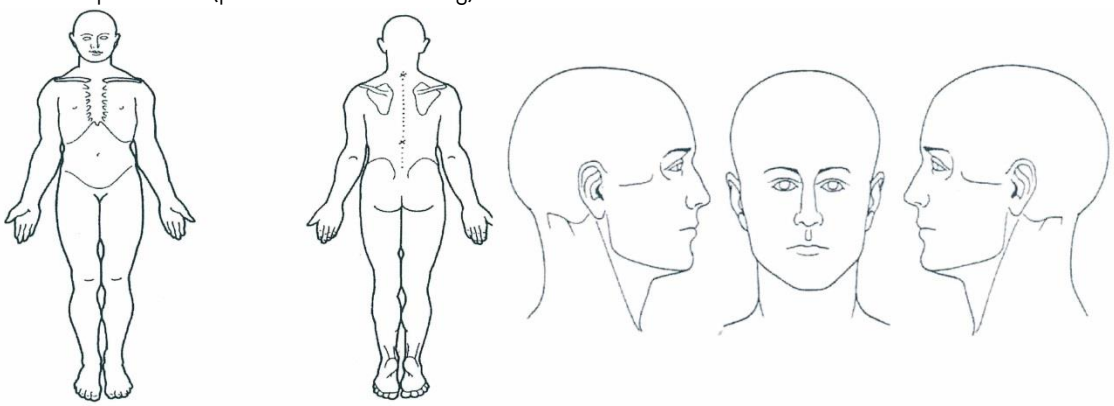
City, Date_____ Signature_____

Dear Patient,

It is our goal to treat you in an optimal way, which is why we need some information about you and your medical condition. It's our duty to treat this information confidentially. Thank you

Career _____ Hobby/Sports_____

Where do you have problems? (please note on drawing)



1. What are your **main discomforts**?_____
2. Are you in **pain**? ☐ Yes ☐ No
3. Is there a decrease in **flexibility/mobility**? ☐ Yes ☐ No
4. Is there a charge of **sensibility** (numbness/tingle)? ☐ Yes ☐ No
5. Is there a **loss of strength**? ☐ Yes ☐ No

... please turn!

6. Do you have any complaints in your **daily routine**?_____

7. **How long** have you suffering under these conditions?_____

8. Has there been a **cause** for your problems?(fall, accident, etc.)_____

9. What **betters** your discomfort? (activity, movement, calmness, sitting, lie down, walking, etc.)

_____

10. What makes them **worse**? (see above)

_____

11. How **strong** is your **pain at the moment**? (please encircle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (maximal pain)

12. How **strong** is your **pain maximal**? (please encircle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (maximal pain)

13. Do you have your complaints permanent or with breaks in between? (please encircle) **permanent / with breaks**

14. Are your complaints **constant / improved / deteriorating**? (please encircle)

15. Do you feel pain when you **cough / sneeze / press / swallow**? ☐ Yes ☐ No

16. Do you suffer from **imbalance or vertigo**? ☐ Yes ☐ No

17. Are you **pregnant**? ☐ Yes ☐ No

18. Do you have **headaches**? ☐ Yes ☐ No

19. Do you suffer from **dizziness, nausea, fainting** or **dysphagia**? ☐ Yes ☐ No

20. Do you suffer from **diabetes, rheumatism** or **osteoporosis**? ☐ Yes ☐ No

21. Do you have problems with your **internal organs**? (respiration, heartburn, constipation, bladder, etc.) ☐ Yes ☐ No

22. Do you have any other **diseases / allergies**? (e.g. high blood pressure, fever, indisposition) ☐ Yes ☐ No

23. Do you take **medication**? ☐ Yes ☐ No

24. Did you ever have a **tumor** or **cancer**? ☐ Yes ☐ No

25. Do you have **pain at night**? ☐ Yes ☐ No

26. Did you have a **sudden loss of weight** lately? ☐ Yes ☐ No

27. How about **fever** or **highly sweating**? ☐ Yes ☐ No

28. Did you have **accidents** or **operations**? ☐ Yes ☐ No

29. Any other conditions which aren't connected with your main complaints? (sight, hearing, incontinence, etc.) ☐ Yes ☐ No

30. Are you afraid that motion will worsen your complaints? ☐ Yes ☐ No

31. Do you believe your **complaints** will be a protracted long term condition? ☐ Yes ☐ No

32. Which type of **diagnosis** or **treatments** has been done so far? (please encircle)

x-ray, CT, MRI, shots, massages, physical therapy or something else:

_____

What are your **expectations** and **goals** with this therapy ?_____

_____