

# Patient questionnaire

If referral, address of doctor or therapist:

**Registration for special treatment:**

Check-up

Your information on this form may be important for your therapies. Please take enough time and answer the questions completely. If there is not enough space, please enclose a supplementary sheet. Your answers will also help us to plan the examinations at the initial consultation.

**Gender**     Female     Male

**Patient no.** (will be filled in by us)

**Last name**

**Family** (for children under 18 years)

**First name**

**Date of birth**

**Home address\***

\*for all correspondence and deliveries of goods

**Country/postcode/place**

**Telephone (daytime)**

**Mobile**

**Telephone (private)**

**Telefon (business)**

**Telefax (private)**

**Telefax (business)**

**E-Mail**

→ **Other contact**

**Civil status**

**Job**

**Children** (number, gender, year of birth)

**Do you have a dental x-ray (OPT)?**

Yes     No

**Contact person in case of emergency**

(Name, address and telephone number)

**Which health insurance company do you have basic insurance with?**

Name

Postcode/place:

Insurance No.

**With which health insurance company do you have supplementary insurance?**

Name

Postcode/place:

Insurance No.

↓ Please leave this column empty.

**1. What is your main problem?**

**2. What other diseases and symptoms do you currently have?**

**3. What illnesses, operations and accidents have you already had in your life) (Please specify chronologically)**

**4. What family diseases or disorders exist?**

**5. What stresses are you exposed to in your social environment (psychological stress, etc.)?  
Are you exposed to electromagnetic or other house contaminants? If so, which?**

**6. What medications are you currently taking? (biological and chemical)**

**Size in cm**

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**Weight in kg**

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**Please tick the appropriate items and describe them briefly if necessary.**

	<u>normal</u>	short of	too much	Remarks
1. <u>Appetite / thirst</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
2. <u>Digestion / bowel movement</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3. <u>Physical exercise</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

	no	yes	Remarks
4. <u>Sleep disorders</u>	<input type="radio"/>	<input type="radio"/>	<hr/>
5. <u>Dental problems</u>	<input type="radio"/>	<input type="radio"/>	<hr/>
6. <u>Do you have amalgam fillings?</u>	<input type="radio"/>	<input type="radio"/>	<hr/>
7. <u>Do you have root-treated teeth?</u>	<input type="radio"/>	<input type="radio"/>	<hr/>
8. <u>Heart complaints / heart conditions</u>	<input type="radio"/>	<input type="radio"/>	<hr/>
9. <u>Shortness of breath, asthma</u>	<input type="radio"/>	<input type="radio"/> *	<hr/>
10. <u>Restlessness, concentration problems, fatigue</u>	<input type="radio"/>	<input type="radio"/> *	<hr/>
11. <u>Disorders in the bladder and genital area</u>	<input type="radio"/>	<input type="radio"/> *	<hr/>
12. <u>Vomiting, nausea, flatulence</u>	<input type="radio"/>	<input type="radio"/> *	<hr/>
13. <u>Back problems, joint problems</u>	<input type="radio"/>	<input type="radio"/> *	<hr/>
14. <u>Do you have difficulties with climbing stairs?</u>	<input type="radio"/>	<input type="radio"/>	<hr/>
15. <u>Do you need a wheelchair?</u>	<input type="radio"/>	<input type="radio"/> *	<hr/>
16. <u>Allergies</u>	<input type="radio"/>	<input type="radio"/>	<hr/>
17. <u>Psychological problems</u>	<input type="radio"/>	<input type="radio"/>	<hr/>
18. <u>Do you eat diet?</u>	<input type="radio"/>	<input type="radio"/>	<hr/>

\* If so, which ones? (Please enter under comments.)

**19. What are your smoking habits?**

**20. How is your alcohol consumption?**

**21. Holistic treatment body-mind-spirit**

We always treat the whole person and have our own department for energetic therapies. For an optimal therapy success it can be of central importance to also treat emotional/soul/energetic factors.

Would you like that?      Yes      No

If yes, you have the opportunity to provide further details here:

**22. Which doctors are currently treating you?**

**23. Who told you about us?**

**Please return this form completely filled out and signed by mail, fax or e-mail.**

Biologische Tagesklinik Dr. Rupp  
Hauptstrasse 2  
9053 Teufen (CH)  
E-Mail: [info@biologische-tagesklinik.ch](mailto:info@biologische-tagesklinik.ch)

We will contact you within 10 working days to arrange an appointment. You do not necessarily need a medical referral for your registration. If you do have one, please enclose it.

**Thank you very much and best regards**

The team of the biological day clinic Dr. Rupp