Anamnese-Bogen

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PRAXIS belladonna

A warm welcome to my surgery!

To prepare for your visit to my practice, please print out and complete this medical history form and bring it with you to your first appointment. The more I learn about you, the better I can support your health. We can discuss any points that are unclear to you during the appointment.

Surname, first name: ..... **Birth date:** ....:::.....

Street: ..... **Postcode, city:** .....

Profession: ..... **E-Mail:** .....

Phone number: ..... **Mobil number:** .....

Statutory insurance: ..... **Private, supplementary:** .....

Height (cm): ..... **Weight (kg):** .....

Waist (cm): ..... **Hip (cm):** .....

How did you find out about me?

O Transfer by: ..... O on recommendation of: .....

O Practice website: ..... O Other: .....

What concern brings you to me?

.....

.....

How were you born? O spontaneous birth O Caesarean section O don't know

Were you breastfed? O yes ..... month O no O don't know

Relationships? O living alone O divorced O married
O in a stable partnership O other

Children? O I have ..... children O no children
O I had ..... Miscarriages O unfulfilled desire for children

Current professional activity? ..... Weekly working hours: ..... h

Are you currently receiving treatment?

O Doctor O Naturopath O Psychotherapist O Physiotherapist O Osteopath

Now please make a note of **all (!)** medication and food supplements that you are currently taking, including contraceptive measures, sprays and emergency medication (painkillers, allergy tablets, sleeping tablets, etc.).

Medication / food supplement	**Daily intake (dose)**	**if required**
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

If there were any abnormalities in previous laboratory tests?

O never or The following were conspicuous:

O Liver values O Kidney values O Blood sugar levels O Cholesterol
O Iron shortage O Inflammation values O Thyroid values O Other .....

Antibiotic treatments

(whether for colds, cystitis, dental problems, operations...)

in your last 5 years of life a total of ..... times

Smoking habits

I'm a non-smoker O always O since ..... years

I smoke an average of about ..... cigarettes per day / I smoke other stuff: .....

Do you still have amalgam fillings?

O no O yes, I have ..... amalgam fillings

Did you previously have amalgam fillings that have since been removed?

O no O yes, I have ..... amalgam fillings

Do you have implants? O no O yes, I have.....

Overcrowned teeth? O no O yes, I have.....

Root-filled / dead teeth? O no O yes, I have .....

Have you received the corona vaccination? O no O yes, a total of ..... times

O Moderna O Biontech/Pfizer O Astrazeneca O Johnson & Johnson O Sonstige

Previous operations

..... Year:.....

..... Year:.....

..... Year:.....

..... Year:.....

..... Year:.....

..... Year:.....

..... Year:.....

..... Year:.....

How many litres of water do you drink on average per day?

approx. ..... litres

Digestive habits and complaints

How often you have a bowel movement? ..... times a day; if not daily: approx. ..... times a week

O regularly O irregularly

How often do you eat or drink the following foods on average?

	(almost) never	now and then	several times a week	1x daily	several times a day
Milk	O	O	O	O	O
Cottage cheese	O	O	O	O	O
Yoghurt	O	O	O	O	O
Cheese	O	O	O	O	O
Eiggs	O	O	O	O	O
Bread / rolls	O	O	O	O	O
Cereals	O	O	O	O	O
Noodles / Pasta	O	O	O	O	O
Cake	O	O	O	O	O
Sweets	O	O	O	O	O
Meat	O	O	O	O	O
Fish	O	O	O	O	O
Sausage	O	O	O	O	O
Vegetables	O	O	O	O	O
Fruits	O	O	O	O	O
Coffee	O	O	O	O	O
Black tea	O	O	O	O	O
Still water	O	O	O	O	O
Sparkling water	O	O	O	O	O
Fruit juices	O	O	O	O	O
Coca Cola	O	O	O	O	O
Sweet drinks	O	O	O	O	O
Energydrinks	O	O	O	O	O

What illnesses have you had or do you have and since when?

Chronic intestinal diseases	O	seit: .....
Neurodermatitis	O	seit: .....
Asthma	O	seit: .....
Psoriasis	O	seit: .....
Hay fever	O	seit: .....
other allergies	O	seit: .....
Others	O	seit: .....

Please rate the complaints or symptoms that apply from 1 (very mild) to 6 (very severe). Please leave any symptoms that do not apply blank.

	Indication **Do you suffer from:**	**Grade 1-6** (Degree of load)
Stool behavior		
1.1	Constipation?	
1.1.1	Cramped, difficult bowel movements?	
1.1.2	Constipation better if you take your time? (*bowel treatment*)	
1.1.3	Constipation better with exercise and / or drinking?	
1.2.	Stool / consistency irregularities	
1.2.1	Is it fatty stool? (floats up)	
1.2.2	Is it mushy stool?	
1.2.3	Stool smells sour?	
1.2.4	Intestinal problems in general? Stress related? *(Improve intestinal flora)*	
1.2.5	Lower back problems that feel better after stool?	
1.2.6	Feeling of pressure on the right side of the upper abdomen? *(Improve intestinal activity through liver detoxifikation)*	
1.3	Do you suffer from stress-related diarrhoea?	
1.3.1	Diarrhoea acute?	
1.3.3	Diarrhoea alternating with constipation?	
Digestion		
2.1	Flatulence / Winds (Flatulence is painful and remains in the intestine, winds go out.)	
2.1.1	Do you suffer from stress-related flatulence?	
2.1.1.1	Flatulence in general?	
2.1.2	Nonspecific wind / flatulence in lower abdomen? *(Improve stress-related poor intestinal flora.)*	
2.1.3	Nonspecific wind / flatulence in upper abdomen? *(Improve small intestine flora.)*	
2.1.4	Fermentation dyspepsia (Symptom complex of bloating, nausea and belching through to flatulence and diarrhoea)	
2.1.4.1	Fermentations in the belly with sweets? Need for sweets? Winds smell of rotten fruit? *(Carbohydrate metabolism)*	
2.1.5	Wind smells like rotten eggs? *(Protein metabolism disorders)*	
2.1.6	Pressure in the upper abdomen? Air in the upper abdomen? *(Roemheld)*	
2.1.7	Is it smeary stool? (much toilet paper)	
2.2	Do you suffer from general food intolerances?	
2.2.1	Sugar / fruit intolerance or sweet tooth?	

2.2.2	Feeling of overload of stomach / intestine? *(Pancreas disorder stress-related)*	
2.2.2.1	Do you have an unhealthy diet? (Often canteen, fast food, instant meals, soft drinks) *(Pancreatitis, chronic)*	
2.2.3	Do you have the impression that you do not tolerate fatty food and oils well?	
2.2.4	Are you intolerant to animal protein products? Are dairy product, egg intolerances known?	
2.2.5	Do you have a bad feeling in your upper abdomen? *(Histamine breakdown)*	
2.4	Undefinable abdominal pressure to cramps?	
2.5.6	Do you have or have you ever had stomach or intestinal ulcers?	
2.7	Do you have or have you ever had haemorrhoids?	
2.7.2	Have you ever had food poisoning? *(Liver poisoning due to backlog)*	
Appetite		
3.1	Do you have general stomach complaints?	
3.1.3	Stomach discomfort with air and upper abdominal pressure after eating in general?	
3.1.4.1	Stomach discomfort with air and upper abdominal pressure after eating stress-related?	
3.1.6	Stomach irritation with heartburn?	
3.1.7	Stomach problems with stress, nervousnes, hunger? *(Stomach neurosis)*	
3.2	Stomach acidity / urge to vomit / belching / heartburn?	
3.2.6	Burping sour in general?	
3.2.7	Stomach pain with burning?	
3.2.8	Have you ever been diagnosed with Helicobacter?	
3.2.11	Heartburn due to stress?	
3.3.1	Long lingering of food in the stomach, globus sensation in the stomach?	
3.4	Do you suffer from loss of appetite?	
3.4.1	Loss of appetite due to stress?	
3.4.2	Loss of appetite with a cold stomach feeling?	
Allergies		
4.1	Do you suffer from allergies in general?	
4.2	Do you suffer from hay fever?	
4.3	Allergies to animal proteins (dairy products, eggs, meat) known?	
4.3.3	Allergies to antibiotics, penicillin, medications?	
4.3.4	Allergies to preservatives?	
Thirst / Kidney / Bladder		
5.1	Do you have a lack of thirst?	
5.2	Frequent blister irritations and cold feet?	
5.2.1.1	Blister irritation and thick legs, sock print in the evening?	
5.2.2	Do you often have to urinate?	
5.3	Bladder infections after sexual intercourse? Currently a bladder infection?	
5.5	Urination disorders, also stress-related?	
5.6	Do you have to urinate often at night?	
5.7	Difficulty holding water since giving birth?	
5.8	Bedwetting in children	
5.10	Burning when urinating?	
5.11	Have you ever had kidney problems?	

5.12	Do you have acute kidney problems right now?	
Sleep		
6.1	Do you have trouble falling asleep?	
6.2	Do you have trouble falling asleep?	
6.2.1-6.2.6	If so, at what time approximately?	
Movement / Breathing		
	You should exercise every day until you break out in a pleasant sweat.	
7.1	How bad do you think your lack of exercise is, if any?	
7.1.1	Do you suffer from breathing problems along with heart problems?	
7.1.3	Are you breathing very shallowly?	
7.1.4	Do you breathe heavily and shallowly when stressed?	
7.2.1	Are you short of breath? (when climbing stairs)	
7.3	Do you periodically suffer from shortness of breath?	
7.4	Heavy breathing with low blood pressure?	
7.6	Are your bronchial tubes congested?	
7.7	Cough?	
7.7.1	Cough with a lot of mucus?	
7.7.2	Often cough irritation?	
7.7.4	Just acute cough?	
7.8	Do you suffer from chronic bronchitis?	
7.9	Do you have sticky white sputum?	
7.10	Do you have acute pneumonia?	
7.11	Do you suffer from asthma?	
Skin		
8.1	Do you have dry skin?	
8.2	Is your skin easily irritated? (rashes more often, smells sour)	
8.3	Do you occasionally suffer from eczema, boils?	
8.3.4	Do you have oily skin?	
8.5	Do you suffer from connective tissue weakness?	
8.5.3	Weakness of the connective tissue with spider veins?	
8.5.4	Water retention in the tissue?	
Scars		
9.1 – 9.3	Do you have any scars? (injuries, burns, cuts) How many?	
9.4	Do you suffer from hard tension? (Hardening in the muscle tissue, neck, back).	
Musculoskeletal system		
10.1	Do you suffer from general joint pain?	
10.1.1	Groin pain?	
10.1.2	Neck pain?	
10.1.2.1	Neck pain on one side?	
10.1.3	Pain in the flanks?	
10.1.4	Pain in the upper extremities?	
10.1.5	Pain in the rib area?	
10.1.6	Pain in the shoulder blade?	
10.2	Cramping pain?	
10.3	Muscle pain?	
10.4	Rheumatic pain in soft tissues, pain comes and goes?	
10.6	Calf cramps?	
10.7	General spinal pain	
10.7.3	Spinal pain of a section?	
10.7.4	Disc wear with pain?	
10.8	Does your neck feel blocked?	

10.9	Does your tailbone/crossbone feel blocked?	
10.10	Do you have hip pain / hip osteoarthritis?	
10.11	Foot or knee pain?	
10.11.1.1	Ankle problems chronic?	
10.11.1.3	Complaints in the knee joint?	
10.12	Elbow joint discomfort?	
10.13	Shoulder joint pain?	
10.14	Wrist pain, carpal tunnel syndrome?	
10.14.4	Tendinitis in the wrist?	
10.15	TMJ problems, chewing problems?	
10.17	Dupuytren's contracture? (especially ring or little fingers can no longer be stretched)	
Defense / Immune System		
11.1	Do you often have a cold, runny nose? *(Defense increase)*	
11.2.5	Is there a known autoimmune tendency?	
11.3	Do you often have the flu?	
11.4	Do you often have a fever?	
11.4.1.1	Do you have a febrile inflammation involving the neck area?	
11.5.3	Tonsillitis?	
11.5.4	Do you have difficulty swallowing?	
11.6	Sinus problems with a cold?	
11.7	Do you have a sinus infection?	
11.8	Is your nose blocked?	
11.9	Do you suffer from odor loss?	
Ears / Hearing		
11.10	Hearing/ear problems in general?	
11.10.1.1	Do you have an earache?	
11.10.2	Chronic ear infection?	
11.11	Do you suffer from hearing loss?	
11.11.1	Have you had a hearing loss?	
11.11.3	Do you suffer from deafness/hard of hearing/hearing disorders?	
11.11.6	Do you suffer from tinnitus?	
Teeth		
12.1	Do you suffer from diffuse toothache?	
12.2	Deep dental problems / dental foci?	
12.3	Do you suffer from toothache?	
12.4	Do you have loosened teeth?	
12.5	Do you have periodontal disease?	
12.6	Do you have gum disease?	
Lymph		
13.1	Do you suffer from lymphatic congestion? *(Lymph Activation)*	
13.1.2	Do you have side stitches more often?	
13.1.4	Do you suffer from lymphedema?	
13.1.6	Extremely swollen legs? (Elephantiasis)	
Nervous system		
14.1	Do you suffer from pulling nerve pain?	
15.1	Headache?	
15.1.2	Neck headache?	
15.1.3	Head pressure in the middle of the head?	
15.1.4	Head pressure in the forehead area?	
15.1.5	Head pressure total and cranial area?	
15.1.7	Back of the headache?	

15.1.8	Headache left side and crown area?	
Psyche / Vitality		
16.1	Do you often have aggression?	
16.1.2	Are you often stressed? *(Regulate adrenaline release)*	
16.2	Do you experience feelings of anxiety?	
16.3	Do you suffer from fatigue?	
16.3.2	Great fatigue?	
16.4	Lack of strength?	
16.5	depressed mood/worry/gloom?	
16.5.3	depressed mood after anger?	
16.5.4	depressive mood after heartbreak?	
16.6	Do you often feel emotionally blocked?	
16.7	Do you have the impression of a lack of energy with too little oxygen?	
16.8	Do you feel exhausted? *(Lack of vitality)*	
16.8.1	Do you lack strength and zest for life?	
16.9	Do you tend to shiver and freeze easily?	
Cardiovascular and vascular		
17.1	Is your blood pressure elevated?	
17.2	Is your blood pressure too low? *(Tonify circulation)*	
17.2.1	Circulatory weakness, support, dizziness?	
17.2.3.1	Blood pressure fluctuations?	
17.3	Support circulation *(tonify)*	
17.5.2	Heart sensations during stress? *(Improve heart activity)*	
17.5.2.1	Burning in the legs?	
17.5.3	Tachycardia?	
17.6	Chest tightness?	
17.7	Angina pectoris?	
17.8	Heartache?	
17.8.2	Heart pain due to lack of oxygen?	
17.8.3	Heartache due to emotional stress?	
17.8.6	Heart problems due to air in the stomach? *(Meteorism, Roemheld)*	
17.10	Venous insufficiency? *(due to portal vein congestion)*	
17.10.3	venous weakness, vein ectasia *(venous couperosis), (improvement of respiratory power)*	
17.10.4	Varicose veins? *(Strengthening heart vitality)*	
17.11	Phlebitis? *(Phlebitis due to portal vein congestion)*	
17.11.1	Vein inflammation (phlebitis) painful?	
Addiction Treatment		
18.1	Do you smoke? *(Addiction treatment 1)*	
18.2	Alcohol daily? *(Addiction treatment 2)*	
18.3	Other addictions *(Addiction treatment 3)*	
Hormones		
19.3	Thyroid regulation *(also goiter/truma)*	
19.3.1	Goiter? Struma? (Thyroid regulation also goiter/struma)	
19.3.3	Thyroid problems in general?	
19.3.4	Hyperthyroidism?	
19.3.5	Hypothyroidism, -exhaustion?	
19.3.6	Thyroiditis (inflammation of the thyroid gland)?	
19.3.7	Choking sensation? (Thyroid)	
19.4	Genital area painful?	
19.5	Menstrual cramps	
19.5.1	Menstruation strong?	

19.5.1.5	Menstruation, not breastfeeding?	
19.5.2	Menstruation, absent?	
19.5.4	Menstrual pain?	
19.5.6	Vaginal discharge (leucorrhea) *(optional vaginal smear in 1st cup)*	
19.5.7	Menopausal symptoms?	
19.5.8	Morning sickness?	
19.6	Potency difficulties?	
19.6.3	Impotence?	
19.6.4	Seed loss?	
Eyes		
20.1	Eye strain?	
20.1.1	Nearsightedness and farsightedness?	
20.1.2	Tear flow?	
20.2	Eye diseases? Veil before the eyes, night blindness, conjunctivitis, myopia?	
20.3	Eye pain, redness, inflammatory?	
20.3.3	Conjunctivitis due to stress?	
20.4	Eye pain? (also haze formation in the eye)	
20.6	Intraocular pressure elevated? *(Liver congestion)*	
20.6.1	Pressure on the eyes *(outflow disorder)*	
20.7	Visual disturbances? *(Dizziness)*	
20.9	Cataract early stage?	
20.10	Corneal dystrophy / degeneration?	
20.11	Night blindness?	
20.12	Color blindness?	
Blockades		
21.7.1	Are you taking chemical medications / opiates? *(Blockade by allopathics / opiates)*	
21.7.3	Have you had any operations? *(Blockage due to anesthetic)*	
Cellulite		
22.1-22.1.8	Do you have cellulite?	

What do you expect from my treatment?

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What goals do you want to achieve?

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Would you like to be informed about special offers from PRAXIS BELLADONNA?

O yes O no

Many thanks for your co-operation!