Patient Information

Last name: First name: Birthday:

Street: Postcode: City:

Phone:

Mobile: E-mail address:

Fax number:

Profession: Current occupation/ Company:
Since when:

Name of health insurance:

Private supplementary pension/ aid: Yes / No

Patient questionnaire

1. For what ailments are you looking at us? (Please provide any existing complaints, even if they previously were for you as untreatable, including those to which you have already "accustomed".) Since when these complaints (month, year) exist?

2. What diseases did you have in your life? When these occurred (month / year)? Have you ever been operated on? Why? When? (Head, ear, thyroid, lungs, heart, stomach, intestines, liver, gallbladder, pancreas, spleen, kidneys, bladder, prostate, uterus or ovaries, breast, bone)

_____
_____
_____

3. What medications are you taking a currently? (Name, amount)

_____
_____
_____
_____

4. Who is your family doctor or are your doctors? (Name, address, telephone number)

_____
_____
_____
_____

basic history

General

5. Exercise regularly? Yes ☐ What? _____ ☐ No

6. What is your favorite color? _____

7. What is your favorite season?

spring ☐ summer ☐ late summer ☐ autumn☐ winter ☐

8. Which room temperature do you prefer? cool ☐ hot ☐ nor ☐

9. Which beverage temperature you prefer? cold ☐ hot ☐ nor ☐

10. Which flavor would you prefer?

sharp ☐ salty ☐ sweet ☐ sour ☐ bitter ☐

11. Which flavor you do not like?

sharp ☐ salty ☐ sweet ☐ sour ☐ bitter ☐

12. Do you regularly have a certain taste in the mouth, for example in the morning after waking up?

No ☐ sweet ☐ sour and/ or salty ☐ foul ☐ bitter ☐

13. How would you rate your overall physical condition?

Normal ☐ vigorously ☐ weak ☐

14. Were you a child once seriously ill? No ☐ Yes ☐ What?

_____

_____

_____

Sleep

15. Do you suffer from insomnia? Yes ☐ "I do not get to bed at night"☐
very early wake ☐ falling asleep ☐ asleep ☐ no ☐
16. Do you feel rested after sleeping? Yes ☐ No ☐
17. Do you dream much? Yes ☐ No ☐
18. Do you suffer from fatigue?
Always☐ after eating ☐ no ☐ morning☐ noon☐

sweat

19. You sweat during the day or at night reinforced?
daytime☐ at night☐ I do not sweat strengthened ☐
20. Do you suffer from spontaneous sweating? Yes ☐ No ☐

hunger

21. How is your feeling hungry? Cravings ☐ hunger appetite☐
much hunger☐ often hungry, but can eat a little bit ☐ sweet cravings☐

thirst

22. How is your thirst? much thirst ☐ little thirst ☐ normal thirst ☐
for cold drinks☐ for warm drinks ☐

Micturition (urination)

23. How many times per day you need to urinate? _____ times
24. Do you need to urinate at night? How often? No ☐Yes ☐ _____ times
25. How much water you need to pass?
small amounts☐ large amounts ☐ normal amounts ☐
26. What color is your urine? dark☐ light☐ yellow☐ normal☐

bowel movement

27. How often do you have bowel movements?
less than once a day ☐ more than once a day☐ less than every 2 days☐
every 2 days☐

28. What is the nature of bowel movements? (Multiple choice))
with mucus ☐ with blood ☐ soft ☐ mushy ☐ watery ☐ firmly☐ dry☐ dropping-shaped☐ malodorous☐ partly undigested food ☐

In pain (e.g .: joint pain, abdominal pain)
29. What is the character of the pain?
pulling☐ dull ☐ spasmodic ☐ stinging☐
30. Where is the pain located?
_____
31. What relieves the pain?
Refrigerant☐ moisture☐ nor☐ Food ☐ pressure☐ heat ☐
32. What aggravates the pain?
Refrigerant☐ Wind ☐ moisture ☐ pressure food ☐ heat ☐
33. What is the pain connected?
Heaviness☐ much sweating☐ feeling hot☐ feeling cold☐ changing location ☐ same location☐

headaches
34. Where is the pain? Temple ☐ neck ☐ apex☐ side/ ear☐

social history
35. Are you married / you are in a committed relationship? No☐ Yes☐
36. How many children do you have? Yes ☐ _____ Child (ren) no children☐
37. Is there a consisted fertility? No☐ Yes☐
38. Would you describe your personal life as harmoniously? No☐ Yes☐
39. Are you employed?
Yes ☐ Pupil/ Student☐ unemployed ☐ housewife/ houseman ☐ pensioned/ retired☐
40. Proceed like to work? No☐ Yes☐ inactive☐
41. Do you think you work too much? No ☐ Yes ☐
42. Do you need to feed a needy relatives? No ☐ Yes ☐

History on the 5 elements

WOOD

43. Are you irritable in stressful situation? No☐ Yes☐

44. You often feel a sense of anger? No☐ Yes☐

45. Do you know the feeling of having a "lump in the throat"? No☐ Yes☐

46. at the following symptoms of eye Are you having? Refractive☐

burning inflammation ☐ night blindness☐ photosensitivity☐ dry eyes☐ error☐

blurred vision☐ scotoma (even with glasses) ☐

oblurred vision

47. Do you have brittle nails? No☐ Yes☐

48. Do you have a feeling of pressure in the upper abdomen? Yes☐ No☐

49. Have an aversion to the following foods? coffee☐ greasy food☐ garlic☐

50. Do you have gallstones? No☐ Yes ☐

51. Would you be described as sensitive to wind? Yes ☐ No☐

52. Do you tend to muscle tension? No ☐ Yes ☐

53. Do you tend to tendons induration/ tendon shortening of hand or foot? No☐ Yes☐

54. Is it easy for you to decide? No☐ Yes ☐

FIRE

55. Do you suffer from palpitations? No☐ Yes ☐

56. How does your heart beat? slowly☐ fast☐ irregularly☐ normal☐

57. Do you know of one or more of the following symptoms? restlessness☐ no concentration☐ Ängst-sensitivity ☐ forgetfulness☐ problems☐

58. Do you tend to hoarseness? No☐ Yes☐

59. Do you experience voice disorders such as Stuttering, finding words? No☐ Yes☐

EARTH

60. Do you have cold hands or feet? No ☐ cold hands☐ cold feet☐

61. Do you have varicose veins? hemorrhoids? No☐ Yes ☐

62. Do you tend to water retention in the body?

No☐ Legs☐ finger joints☐ eyelids ☐ other☐ _____

63. Do you tend to be overweight? No☐ Yes☐

64. Do you feel that you have the limb (for example, when climbing stairs) are difficult? No☐ Yes☐

65. Come morning "bad in the corridors"? No ☐ Yes ☐

66. Are you brooding? Get much worry? No ☐ Yes ☐

67. Do you tend to melancholy or depression? No ☐ Yes ☐

68. Do you suffer from any of the following symptoms?

Flatulence☐ abdominal☐ belching nausea☐ fullness after eating☐ heartburn☐ cramps☐

69. Is your sense of taste is reduced? Yes☐ No☐

70. Have you ever had a gastritis or an ulcer? No ☐ Yes ☐

71. Do you have to be sick often? No ☐ Yes ☐

72. Do you feel pain / discomfort during bowel movements? No ☐ Yes ☐

73. Is there a food intolerance? No☐ Yes ☐

74. What form does the incompatibility? Diarrhea ☐ vomiting rash☐

METAL

75. Do you smoke? No ☐ Yes☐ How many cigarettes a day? _____

76. Do you have allergies to pollen or food? No ☐ Yes☐

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77. Do you have symptoms such as pressure or tightness in the chest?

Yes, under load☐ alone☐ no☐ yes☐

78. Do you have temporarily breathlessness or asthmatic complaints?

Yes ☐ No☐ night ☐ daytime ☐

79. Do you often getting infections of the respiratory tract (colds, flu, bronchitis)? No ☐ Yes☐

80. Do you suffer from dry cough? No☐ Yes☐

81. Do you have ejection? No ☐ clear ejection ☐ yellow/ thick ☐ runny☐

82. Can you light or heavy cough? easy☐ difficult☐

83. Do you often mucus in the nose or a cold?

No ☐ clear☐ yellow/ viscous☐ mucus☐ runny☐

84. Do you suffer from a chronic stuffy nose or nasal polyps? No ☐ Yes ☐

85. Is your sense of smell is reduced? No ☐ Yes ☐

86. Do you have any of the following symptoms? blemished skin ☐ dry skin ☐ eczema Psoriasis☐ allergic skin reaction☐ acne☐

87. Is there a bereavement or separation situation to which you have to think many times? No ☐ Yes ☐

88. Do you tend to sadness? No ☐ Yes ☐

WATER

89. Do you tend to uncontrolled loss of urine (incontinence / urinary incontinence)?

No ☐ Yes☐ When?_____ Coughing sneezing☐ laugh spontaneously☐

90. As is generally the color of your urine?

light / dark water☐ normal yellow☐ clear☐

91. Do you have frequent bladder infections? No ☐ Yes ☐

92. Do you suffer from hearing loss? No☐ Yes ☐

93. Do you suffer from tinnitus? No☐ Yes ☐

94. Do you suffer from a disease of the prostate? No ☐ Yes ☐

95. Do you suffer from erectile dysfunction? No ☐ Yes ☐

96. What is your sexual drive? normal ☐ much☐ little ☐

97. Do you have dental problems? (Root inflammation, dead teeth etc.)

No ☐ Yes ☐

98. Do you tend to fractures? No ☐ Yes ☐

99. Do you have back pain? No ☐ Yes☐

100. Do you have knee problems / weak knees? No ☐ Yes☐

101. Do you tend to hair loss? No ☐ Yes ☐

102. Did you have early gray hair? No ☐ Yes ☐

103. Do you have anxiety? No ☐ Yes ☐

104. Is your performance reduced? No ☐ Yes ☐

COLD - HEAT

105. Do you suffer from bleeding gums? No ☐ Yes ☐

106. Do you have ulcers (canker sores example, herpes) in the range of gums, tongue or lips? No ☐ Yes ☐

107. Do you have discharge from the urethra / vagina?

No ☐ Yellowish☐ whitish☐

108. Do you suffer from a dry mouth? No☐ Yes☐

109. Do you have an increased itching of the skin? No ☐ Yes ☐ Where?

_____

110. Do you have a heat sensation in hands and feet? No☐ Yes☐

MUCUS

111. Do you have dizziness or balance problems? No☐ Yes☐

112. Do you have dizziness with slight head or with a heavy head?

113. Do you feel numbness or tingling sensations on the body?

No ☐

Yes ☐ where_____

The following questions are only for women

MENSTRUAL HISTORY

114. What is the distance (in days) between two menstrual periods?

less than 32 days☐ every 28 - 32 days☐ more than every 28 days☐

no menstruation ☐

115. Do you have bleeding between periods? No ☐ Yes ☐

116. How many days will stop your bleeding? _____

117. What is the nature Your menstrual blood?

thin☐ normal☐ spotting☐ lumpy☐ dark red☐ light red☐

118. Do you have related to the menstrual pain?

No pain ☐ before bleeding☐ during bleeding ☐

119. Do you feel pain / swelling sore breasts? No ☐ Yes ☐

120. Do you suffer from hot flashes?

Yes, with sweating ☐ Yes, without sweating☐ No ☐

121. Take hormones or "the pill" one? Yes, hormones☐ No☐ Yes, "the pill" ☐

122. Number of pregnancies:

123. Number of births:

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Consent to billing

There currently is not possible to direct billing of treatments with Traditional Chinese Medicine between the Centre for Traditi-onal Chinese and Integrative Medicine and the statutory or private health insurance. The ex-statement of the services provided by us is therefore carried out directly with you. This means that you will be charged for the Be-treatment with traditional Chinese medicine, regardless of any reimbursement of costs of treatment by their health insurance or insurance, invoiced directly. The private health insurance companies and insurance recoverable th experience, at the request of the majority of the costs incurred. They will each receive after treatment or initial examination of our application, the receipt / invoice for the interim every time the appointment by debit card or in cash amount to be paid. The final invoice will be sent after the treatment series. You can submit your health insurance company for reimbursement then. If you get a recipe for traditional Chinese medicinal therapy, we would like to point out that the cost for traditional Chinese medicines are generally not reimbursed by health insurers. Other involved in the treatment liquidation legitimate Thera-therapists and doctors (third), provided that they are used for treatment, fee requirements can provide. An addition-evasion by third parties is only with the consent of the patient / contractor. It is possible that these are also Thera-therapists and doctors outside the clinical setting (St. Hedwig Hospital).
The extent of any refund claims against health insurance or aid agencies does not affect the amount of the calculated fee.
Thank you for your timely appointment cancellation. An appointment canceled 24 hours before the appointment is free of charge. This applies both to the Erstgesprächstermine as well as for follow-up appointments. At a later cancellation, the handling fees or GebüH-ren are calculated for the unperceived Initial Appointment in full.

The preceding information sheet for accounting I have read and its contents with approval genome-men.

_____
Berlin, date

_____
Signature patient

Use of custom health care/ treatments with Traditional Chinese Medicine

Personal statement by the patient:

Name

Wish the private treatment benefits of Traditional Chinese Medicine, which are defined jointly during the first examination to me.
These benefits of Traditional Chinese Medicine are (GOÄ) calculated as below me on the basis of the official rate of doctors:

Numeral designation of power factor/ Amount€
A30 Initial examination by the methods of Traditional Chinese Medicine/ 168€
269a Treatment methods of Traditional Chinese -rule Medicine (for example acupuncture, tuina - massage) each session/ 68€
269a Acupuncture in eye area (for example macular degeneration) and body acupuncture each session/ 88€
269ak Treatment methods of Traditional Chinese -rule Medicine (creation or adaptation of herbal therapy) each session / 68€
1 + A76 Creating a single recipe/ 30€
A76 Creating a follow-up recipe/ 12- 20€ !! The fee for the herbs granules are directly calculated and in addition by the pharmacies !!
267 Drug infiltration treatment in a body/ 15€
A268 Med. Infiltration treatment, homeopathy, acupuncture and mouth, according to section2 / 25€
3306 Chiropractic intervention on the spine/ 25€
207 Tape association/ 15-30€
5 + 800 + A5802 Magneto therapy testing (AK)/ 50- 100€
A639 Matrix rhythm therapy/ 60€

I am awarethe these services are not part of the service catalog of the legal health insurance companies and therefore, the cost must be of them not well paid or refundable.
In the private health insurance companes, it is under-differently and depends on the contract.

_____

Berlin, date

_____ _____

Signature Center TCM Signature patient

Enlightenment for treatment with the methods of Traditional Chinese Medicine / acupukture

Before a first treatment with the methods of Traditional Chinese Medicine, we would like to point to possible complications:

The first acupuncture treatment is generally carried out in a lying position, this may results in rare cases lead to circulatory problems (V.A by fluid loss, in hunger, after dinner or fatigue).
Despite careful acupuncture treatment can lead to small bruises (so- called hematomes) occur rarely in injury larger blood vessels, nerves or intern organs or infections .
Excessive movement of the patient during the acupuncture treatment should be avoided, so that the needle remains in the engraved localization and a muscular train is avoided on the needle.
Please let us know if an acupuncture needle causes persistent pain, so that they can be drawn or placed differently.
In addition, it can after an acupuncture treatment also to increase fatigue and thus come to the restricted traffic drive and an increase in reaction time.
After the first treatment, it may in rare cases a deterioration of the treated symptoms, the so-called "healing crisis", which is a sign of a blockage solution.
However, you should inform your doctor is-over.
Please inform us prior to the first treatment about any bleeding disorders or therapy with blutverdünnenden medications, any psychiatric disorders and as a woman about the existence of pregnancy, since some points can cause blow-inducing reactions.
Should be carried out at you with a heat treatment (moxibustion in support of acupuncture treatment, infor-vide you, so it does not come to us or one of our staff or employees, if you source appears as uncomfortable or too hot to burn the skin.
If you are treated to support the therapy with cupping, it comes with the correct implementation of the therapy bruising.

The preceding information sheet for acupuncture therapy I have read and taken its content approval.

_____
Berlin, date

_____ _____
Signature Center TCM Signature patient