Medical History

Please take a little of your time to print out and fill in this document. The information required accommodates the diagnosis and treatment of your symptoms.

What brings you to us?

What illnesses, injuries and/or operations have you had in the past?

Do you take medication regularly (pain killers, anticoagulants etc.)?

Do you have any other important Information for us?

Thank you!
Treatment Contract

Full name and address

Date of birth

Tel. Nr.

e-mail address

Attending physician

Recommended to us by

Details of health insurance

Private, supplementary, possibility of refund ...

☐ I have thoroughly read and agree to the terms and conditions, as set out on the website www.frankfurt-chiropractic.com and to be seen in the waiting room.

☐ I hereby confirm that I have been informed as to the form, extent and implementation of treatment, and also as to the urgency, appropriateness and success to be expected following diagnose and therapy; also about possible alternatives. (To be seen on the website www.frankfurt-chiropractic.com and in the waiting room.)

Signed in (place), on (date), at (time)  by (Patient’s name)