



## **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?

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

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

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Do you have any other important Information for us?

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**Thank you!**



## Treatment Contract

Full name and address .....

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Date of birth .....

Tel. Nr. ....

e-mail address .....

Attending physician .....

Recommended to us by .....

### Details of health insurance

Private, supplementary, possibility of refund ...

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- I have thoroughly read and agree to the terms and conditions, as set out on the website [www.frankfurt-chiropractic.com](http://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](http://www.frankfurt-chiropractic.com) and in the waiting room.)

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