

Praxis Lemm

Patient's Questionnaire according to the criteria of holistic medicine

Dear patient

This questionnaire is designed to understand your problem and you as a person. It is also aimed at giving you a greater awareness of your symptoms making it easier to relay them to me during our consultation

Name, First name:		_
Date of birth:	date:	_
Qualification/ Occupation:		<u> </u>
Primarily seated activity: ☐ yes ☐ no	(to be checked in my practice)	
Height:	Blood pressure:	
Weight:	Pulse:	
Marital status: ☐ married ☐ single	abdominal girth:	
Email:	Children:	
	Land line:	_
☐ I do not wish to receive medical newsletter	Mobile:	<u> </u>
Your current medical problems:	1.	<u> </u>
2.	3.	_
4.	5.	_
Which symptoms of the above indicated would	you like to be treated?	<u>_</u>
Which treatment do you prefer?		_
Operations/Surgery:		_
Accidents:		_
Are you allergic to medications,food,pills,etc.?	□ yes □ no	
If so, please list:		
		_
Do you take medications or pills?	no last treatm. with antibiotics:	
If so, please list:		
How often did you take antibiotics in the last 2	years:	_
I confirm the correctness of my entries and	I agree with the storage for internal usage.	
Date, Signature:		
Please specify the following questions:		
	estronger,frequently 4=high,constantly,very often	
General lifestyle		
Do you work too much	2 3 4 Alcohol 1	□ 2 □ 3 □ 4
Do you exercise	2 3 4 Coffee 1	□ 2 □ 3 □ 4
Do you suffer from stress symptoms	☐ 2 ☐ 3 ☐ 4 Smoking ☐ 1	□ 2 □ 3 □ 4
General condition		
Fatigue	4 Chills	□ 2 □ 3 □ 4
Apathetic (mornings)		□ 2 □ 3 □ 4
Reduced appetite	_	□ 2 □ 3 □ 4
	, , ,	

web: www.praxis-lemm.de

Diago aposity the following gu	logtions:		
Please specify the following qu 1=no,never 2=hardly,occas		ger,frequently 4=high,constantly,very oft	en
General signs (continued))		
Tiredness (after sleep)	□ 1 □ 2 □ 3 □ 4	Brittle nails	□ 1 □ 2 □ 3 □
Sudden sweating	□ 1 □ 2 □ 3 □ 4	Easily exhausted	□ 1 □ 2 □ 3 □
Palpitations	□ 1 □ 2 □ 3 □ 4	Fever	□ 1 □ 2 □ 3 □
Cold hands/feet	□ 1 □ 2 □ 3 □ 4	Night sweat	□ 1 □ 2 □ 3 □
Swollen hands	□ 1 □ 2 □ 3 □ 4	Irregular sleep	□ 1 □ 2 □ 3 □
Swollen feet	□ 1 □ 2 □ 3 □ 4	Dark urine	□ 1 □ 2 □ 3 □
Feeling of heaviness	□ 1 □ 2 □ 3 □ 4	Increased thirst	□ 1 □ 2 □ 3 □
Cramps in the calf	□ 1 □ 2 □ 3 □ 4	Reduced thirst	□ 1 □ 2 □ 3 □
Chest pain / heaviness	□ 1 □ 2 □ 3 □ 4	Intolerance to cold or draught	□ 1 □ 2 □ 3 □
Head			
Headache	□1 □2 □3 □4	Face pain	□1 □2 □3 □
Front headache			
Partial headache		• •	
Headache on back of head			
ENT			
	□ 1 □ 2 □ 3 □ 4	Detetemy ventine	
Hard of hearing			
Ringing noise		Balance problems	
Eyes			
Irritated eyes	□ 1 □ 2 □ 3 □ 4	Dry eyes	□ 1 □ 2 □ 3 □
Night blindness	□ 1 □ 2 □ 3 □ 4	Blurred vision	□ 1 □ 2 □ 3 □
Contact lenses, reading classes	□ 1 □ 2 □ 3 □ 4	Eye pressure	□ 1 □ 2 □ 3 □
Back and joint pain			
Low-back pain	□1 □2 □3 □4	Sore neck	□1 □2 □3 □
Weak lumbar region	□ 1 □ 2 □ 3 □ 4	Shoulder pain	□1 □2 □3 □
Sensitivity to cold in	□ 1 □ 2 □ 3 □ 4	Knee problems	□ 1 □ 2 □ 3 □
lumbar region		Lumbago	□1 □2 □3 □
Muscle pain,spasm	□ 1 □ 2 □ 3 □ 4	Tenosynovitis (TSV)	<pre>□ 1 □ 2 □ 3 □</pre>
Pulmonary			
Frequent cold	□ 1 □ 2 □ 3 □ 4	Chest tightness	
Shortness of breath while resting		•	
Shortness of breath with		•	
light work		Smelling problems	
Sweating under strain	□1 □2 □3 □4	Globus syndrome	
Cough		bellend schwach	
Sputum			1
Skin			

Oily,blemished skin

Dry skin

Rash

□1 □2 □3 □4

□1 □2 □3 □4

□ 1 □ 2 □ 3 □ 4

□ 1 □ 2 □ 3 □ 4 Eczema

□ 1 □ 2 □ 3 □ 4 Itchiness

□ 1 □ 2 □ 3 □ 4 Easy bruising

Please specify the following qu		0 1			
·	asionally,rarely	3=stronge	er,frequently 4=high,constantly,very of	ten	•
Sleep					
Difficulty falling asleep	□ 1 □ 2	□ 3 □ 4	Palpitations	□ 1 □ 2	□ 3 □ 4
Difficulty staying asleep	□ 1 □ 2	□ 3 □ 4	Night sweats	□ 1 □ 2	□ 3 □ 4
Early awakening	□ 1 □ 2	□ 3 □ 4	Tingling legs	□ 1 □ 2	□ 3 □ 4
			Hot feet,nights	□ 1 □ 2	□ 3 □ 4
Frequent dreams, nightmares	□ 1 □ 2	□ 3 □ 4	Recurring thoughts, nights	□ 1 □ 2	□ 3 □ 4
Gastrointestinal/Genitour	rinary				
Soft faeces	□ 1 □ 2	□ 3 □ 4	Stomach pressure	□ 1 □ 2	□ 3 □ 4
Solid faeces	□ 1 □ 2	□ 3 □ 4	distention, nausea	□ 1 □ 2	□3 □4
Frequent diarrhea	□ 1 □ 2	□ 3 □ 4	Heartburn	□ 1 □ 2	□3 □4
Frequent constipation	□ 1 □ 2	□ 3 □ 4	Vomiting /nausea	□ 1 □ 2	□3 □4
Increased bowel sounds	□ 1 □ 2	□ 3 □ 4	Bladder neck descent	□ 1 □ 2	□ 3 □ 4
Abdominal cramps	□ 1 □ 2	□ 3 □ 4	Hemorrhoids	□ 1 □ 2	□ 3 □ 4
Flatulence	□ 1 □ 2	□ 3 □ 4	Swallowing difficulty	□ 1 □ 2	□ 3 □ 4
Mouth					
Bad breath/holitosis	□1 □2	□3 □4	Canker sore	□ 1 □ 2	□3 □4
Xerostonia/dry mouth	□ 1 □ 2	□3 □4	Bitter taste in mouth	□ 1 □ 2	□3 □4
Gum bleeding	□ 1 □ 2	□3 □4	Sticky feeling in the mouth	□ 1 □ 2	□3 □4
Herpes infection	□ 1 □ 2			□ 1 □ 2	□3 □4
Genitourinary			9		
Urination during nights	П1 П2	Пз П 4	Dribbling of urine	П1 П2	Пз П4
Frequent urination			Urinary incontinence	\Box 1 \Box 2	□3 □4
Painful urination			Darkened,little urine	\Box 1 \Box 2	□3 □4
Tamaramaton			Clear urine		□3 □4
Legs					
Swollen legs	П1П2	□з □₄	Varicose veins	П1 П2	□3 □4
Skin discolouring				\Box 1 \Box 2	
Menstruation (women on			Cold legs	_ ,	
	_		Manipal diadeana	□1 □2	□3 □4
Irregular period	□ yes		Vaginal discharge		
Painful period	☐ yes ☐ 1 ☐ 2 Ⅰ	□ no	Hormone replacement therapy	_ ,	no
Heavy /scanty bleeding	_		Menopause		no
Breast tenderness before peri-	od 🗌 yes	☐ no	Breast lumps	yes	no no
Births: ☐ normal ☐ s	chwer \square Kais	serschnitt	Years of births:		=
Sexual health					
Impotence	yes yes	☐ no	Frigidity/no interest in sex	□ 1 □ 2	□ 3 □ 4
Infertility	☐ yes	no no	Erectile dysfunction	□ 1 □ 2	□ 3 □ 4
Affectivity					
Choleric	□ 1 □ 2	□ 3 □ 4	Frequent brooding	□ 1 □ 2	□3 □4
Inner unrest	□ 1 □ 2	□3 □4	Sadness	□ 1 □ 2	□3 □4
Tension	□ 1 □ 2	□3 □4	Forgetfulness	□ 1 □ 2	□ 3 □ 4
Anxiety			Difficulty concentrating	□ 1 □ 2	□ 3 □ 4
Feeling depressed	□ 1 □ 2		•	□ 1 □ 2	□ 3 □ 4
Do you like to change some					
Do you like to challye sollle	anny in your ill	o: ii so,pied	SO WITE GOWII.		-
					-
_					•

Eating habits:								
How many meals,include	ling snacks,do you h	ave per da	y?					
How do you eat?	schnell 🔲 lar	ngsam	☐ bewuss	st 🔲 unre	gelmäßig	9		
When do you have your	principal meals?(ho	urs)						
What is your favourite of	lish?							
Do you have food intole	erance? If so,please s	pecify:					_	
Do you have a sweet to	oth? If so,please spe	cify when a	and what:				_	
Do you have cravings?		☐ yes		no				
If so,how often and whe	en:							
What do like to drink?		□ Calia	Faints ata	- for the incident		1 4		
what do like to drink?	mineral water	□ Coke,	Fanta,etc	fruit juice		coffee	☐ tea	
Please indicate,how ofto	en you have the follo	wing:	1=more t	han once a da	y 2= onc	e per day		
3= 3-5 times per week 4=	1-2 times per week 5=2	2-3 times a n	nonth 6=1 ti	imes per month	7=rarely/	never		
Whole meal bread		□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	
Mixed-grain bread		□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	
White bread		□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	
Crisp bread		□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	
Oat flakes,muesli,cornfl	lakes	□ 1	□ 2	□ 3 —	□ 4 —	□ 5 —	□ 6 —	
Potatoes,rice,noodles		□ 1	□ 2	□ 3 —	☐ 4 —	□ 5 —	□ 6 —	
Fruits		□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	
Vegetables,raw vegetab	oles,salads	□ 1	□ 2	□ 3 —	☐ 4 —	□ 5 —	□ 6 —	
Fish		□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	
Meat products		□ 1	□ 2	□ 3 —	☐ 4 —	□ 5 —	□ 6 —	
Meat, poultry, game		□ 1	□ 2	□ 3 —	☐ 4 —	□ 5 —	□ 6 —	
Eggs		□ 1	□ 2	□ 3 —	□ 4 —	□ 5 —	□ 6 —	
Cheese,yoghurt,quark		□ 1	□ 2	□ 3 —	□ 4 □	□ 5 —	□ 6 —	
Milk,buttermilk		□ 1 —	☐ 2 —	□ 3 —	□ 4 —	□ 5 —	□ 6 —	
Cream,créme fraîche		□ 1 □	□ 2 —	□ 3 —	□ 4 =	□ 5 =	□ 6 =	
Butter,margarine		□ 1 =	□ 2 —	□ 3 □ -	☐ 4 □	□ 5 □ -	□ 6 □	
Vegetable oil		□ 1 = :	☐ 2 —	□ 3 □ a	☐ 4 ☐ 1	□ 5 □ -	□ 6 □ 0	
Cake,cookies		□ 1 □ .	☐ 2 — -	□ 3 □ 0	□ 4 □ 4	□ 5 □ 5	□ 6 □ 0	
Sweets		□ 1 □ .	☐ 2 ☐ 2	□ 3 □ 0	□ 4 □ 4	□ 5 □ 5	□ 6 □ 0	
Salty snacks			☐ 2 ☐ 2	□ 3 □ 2	□ 4 □ 4	□ 5 □ 5	□ 6 □ c	
Honey,jam,sugar		□ 1 □ .	☐ 2 ☐ 2	□ 3 □ 0	□ 4 □ 4	□ 5 □ 5	□ 6 □ 0	
Fast food,bratwurst		□ 1 □ 1	□ 2 □ 2	□ 3 □ 2	□ 4 □ 4	□ 5 □ 5	□ 6 □ c	
Convenience food		□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	
Do you wish to get nutr	_		☐ yes	no no				
If so,please write down	what you expect:							

Do you believe that nutrition influences your health?

☐ no

yes
 yes
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √
 √