DIGOTOR

Dear patient,

It is our goal to treat you in the best way possible. In order to do this, we need some information in advance about your person and your complaints. The following questions relate to your main problem.

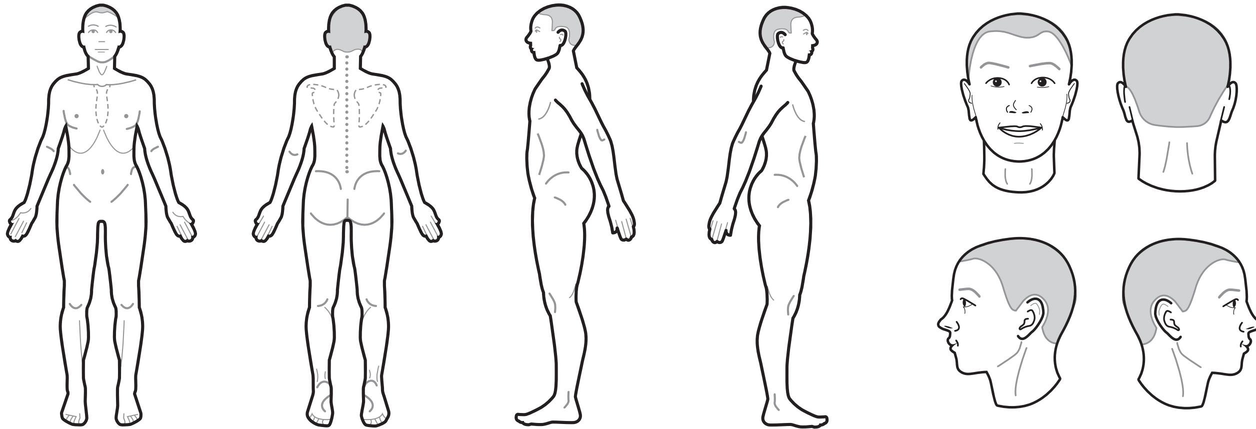
All information is subject to confidentiality and will not be passed on. Thank you for your trust!

Name:____________________ Age: ____________________

Occupation: ____________________ Sport/Hobby: ____________________

Date, Signature: ____________________

1.) Where is the exact location of your physical complaints (please draw in)?



2.) Do you experience any pain? yes ❑ no ❑

3.) Is your mobility changed yes ❑ no ❑

4.) Is your sensitivity changed (burning, tingling, numbness, hypersensitivity, pins and needles)? yes ❑ no ❑

5.) Is your strength changed (lack of strength, paralysis)? yes ❑ no ❑

6.) What are your main complaints in everyday life?____________________

7.) How long have you had your complaints? ____________________

8.) a) What improves your complaints? (please circle)

b) What makes your complaints worse? (please underline)

Activity, restling, lying down, sitting, standing up, bending, stooping, standing, walking, running, lifting, carrying, overhead work, reaching, work, hobby, sport, morning, noon, evening, other: ____________________

9.) How severe is your pain currently (please circle) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10)
(no pain) (maximum pain)

To answer questions 10-18, please consider the past two weeks only:

10.) How intense did your pain feel on average? (please circle) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10)
(no pain) (maximum pain)

11.) Are you often unsure how to deal with your pain appropriately? yes ❑ no ❑

12.) Have you felt strongly disturbed by your pain in the past two weeks? yes ❑ no ❑

13.) Have you been able to walk only short distances because of your pain? yes ❑ no ❑

14.) Did you have bothersome joint or muscle pain in more than one part of your body? yes ❑ no ❑

PLEASE SEE THE SECOND PAGE!

15.) Do you think your condition will last long? yes ❑ no ❑

16.) Do you have any other significant health problems? yes ❑ no ❑

17.) In the past two weeks, have you felt down or depressed because of your pain? yes ❑ no ❑

18.) Do you think it is harmful for someone in your condition to be physically active? yes ❑ no ❑

19.) Did you experience your current pain for 6 months or longer? yes ❑ no ❑

20.) Does your pain exhibit any of the following characteristics?
Burning sensation: yes ❑ no ❑
Feeling of painful cold: yes ❑ no ❑
Electric shocks: yes ❑ no ❑

21.) Do the following complaints occur together with the pain you described and in the same area of your body?
Tingling: yes ❑ no ❑
Pricking: yes ❑ no ❑
Numbness: yes ❑ no ❑
Itching: yes ❑ no ❑

22.) Do you have your complaints: permanent/with interruptions (please circle)

23.) Are your complaints: getting better/staying the same/getting worse/variable? (please circle)

24.) Do you currently have resting/nighttime/continuous pain? (please circle) yes ❑ no ❑

25.) Do you suffer from headaches, gait or balance problems, bladder weakness, dizziness, nausea, fainting spells, lightheadedness, fever, extreme night sweats, difficulty swallowing or double vision? (please circle) yes ❑ no ❑

26.) Do you suffer from vision, speech, hearing problems, incontinence, constipation, morning stiffness, minor bruising, shortness of breath or cramping? (please circle) yes ❑ no ❑

27.) Are you asthmatic, diabetic, have osteoporosis or other diseases? (please circle) yes ❑ no ❑

28.) Are you currently taking any medications (cortisone, blood thinners, beta blockers, etc.)? yes ❑ no ❑

29.) Have you ever had a tumor or cancer? yes ❑ no ❑

30.) Have you unexpectedly lost weight in the last few weeks? yes ❑ no ❑

31.) Have you had an accident/trauma/attack from a fall/surgery that could be related to your complaints? yes ❑ no ❑

32.) Do you smoke? yes ❑ no ❑

33.) How often do you exercise per week
a) 150 minutes at low intensity (heart rate increased, talking is still possible)? yes ❑ no ❑
b) 75 minutes at higher intensity (heart rate increased, talking becomes impossible)? yes ❑ no ❑

34.) Do you engage in strength training 2x a week? yes ❑ no ❑

35.) Do you have difficulties falling asleep? yes ❑ no ❑

36.) Are you able to sleep throughout the night? yes ❑ no ❑

37.) Which diagnostic or therapeutic measures have been performed so far?
x-ray/computed tomography(CT)/MRI/injection/massage/physiotherapy/exercise/other (please circle)

38.) What are your expectations and goals for therapy?______________________________

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Therapist: ______________________________

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