

Medical History Questionnaire

Dear patient!

The details regarding your personal and medical history in this questionnaire will be used for clarifying your clinical picture. It is in your interest to complete this document as thoroughly as possible. Through this, precious time is saved which can be used more appropriately for a discussion or any essential examination.

*Please tick the appropriate boxes clearly. Your answers are subject to medical confidentiality.
Many thanks for your cooperation!*

Contact Data

First Name	
Surname	
Age	
Street	
ZIP / City	
Country	
Telephone	
E-mail	
Skype	

Personal Data

Date of Birth	
Height	
Weight	
Gender	

Profession	
Current Job	
Marital Status	
Nationality	
Children (Age of Children)	

Patient Data

When and how long do you want to come?	From (DD/MM/YYYY): Days ☐ 1 Week ☐ 2 Weeks ☐ 3 Weeks
Basic Insurance Provider:	
Insurance Number.:	
Complementary Insurance Provider:	
Insurance Number.:	
Do you want a cost price quotation?	☐ Yes ☐ No

Emergency contact

Name	
Adress	
Phone	
Email	

Medical History

Which diseases are known in your family
(mother, father, brothers, sisters)?

What is your main problem? (Please mention
the diagnosis and main symptoms.)
Since when are you suffering from it?

Do you experience any complications and pains
in addition? Please refer to the region in where
you are experiencing these and the time
interval.

Which infectious diseases have you gone through or are familiar with? For example, chickenpox, rubella, kissing disease and so on.	
Please attach your vaccination card or mention the vaccinations you have received.	
Have you been vaccinated against Covid?	☐ Yes ☐ No
Which vaccine was used?	
When did the vaccinations take place?	
Did complications arise?	☐ Yes ☐ no
If yes, which?	

Do you have any allergies?	
Which medicines do you take?	
Have you undergone surgeries?	
Have you been in an accident with whiplash?	☐ Yes ☐ No
How do you consider yourself physically?	☐ balanced ☐ strained ☐ stressed
How is your sleep? How many hours do you sleep through?	
What is your blood type?	☐ A+ ☐ A- ☐ B+ ☐ B- ☐ O+ ☐ O- ☐ AB+ ☐ AB-

Diet / Digestion

What do you commonly eat?	☐ Homemade food with meat and fish ☐ Diet rich with vital substances (sufficient vegetables and fruits, meat, fish 1-2 times in a week) ☐ Vegetarian ☐ Vegan, without any animal products
Are there any foods that you cannot tolerate?	
Do you snack? How often in a week?	
Do you drink alcohol and if yes, how often weekly?	
Which food supplements do you take – and how often?	
How many liters of water do you drink daily?	

Which additional beverages do you consume and how much?	
How often do you pass stool daily and in which form?	☐ normal ☐ very hard ☐ mushy ☐ watery
Do you suffer from flatulence?	☐ less ☐ average ☐ strong

Dental Topics

Do you have a dental panorthogram (OPT or panorama x-ray)? (If yes, we kindly ask you to bring it along for a holistic diagnosis.)	☐ Yes, of which date? ☐ No
Do you have or did you have amalgam (silver) fillings?	☐ Yes ☐ No
If yes, when were they removed?	
Were the heavy metals chelated from your body?	☐ Yes ☐ No
If yes, with what and for how long? How many sessions?	

Miscellaneous

How did you find out about us?	☐ Recommendation c	
	☐ Press:	
	☐ Internet:	
	☐ Newsletter:	
	☐ Advertising:	
	☐ Other:	

Intensive Weeks Packages

Our intensive weeks are packages of proven therapy combinations. If you would like to use such a package at a special price, please tick the corresponding week:

- ☐ Health-Check intensive week (7 days)
- ☐ Liver detoxification intensive week (7 days)
- ☐ Immune power intensive week (7 days)
- ☐ Heavy metal detoxification intensive week (7 days)
- ☐ Regeneration intensive week (7 days)
- ☐ Parasite Detox intensive week (7 days)
- ☐ Burn-Out intensive week (7 days)
- ☐ Pain-Therapy intensive week (7 days)
- ☐ Fasting intensive week (7 days)
- ☐ Phoenix program (21 days)

Should you prefer an individual therapy plan, we will be happy to create one for you based on the information in the health questionnaire. You will then receive a corresponding offer.

I agree to the processing of my health data. Of course, these are subject to absolute discretion and will only be stored for medical purposes.

Place & Date		
Signature		

Thank you for your effort,
Your Swiss Mountain Clinic Team