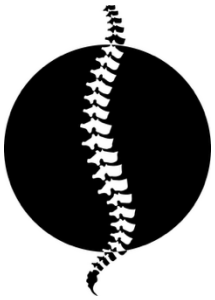
Date:_____

Personal Admission Form | Sporting Spine Regensburg



This questionnaire collects the necessary information that we need to provide the best possible support that is personally tailored to you.
Please take your time for the correct and complete processing. Thank you!

Name:_____Adress:_____

Location:_____PLZ:_____

Date of birth:_____Insurance Co.:_____

Private phone:_____

Mobile:_____

E-mail address:_____

Would you like to be reminded of your appointment?
- Yes, by SMS
- Yes, by e-mail
- No, I don't want a memory

Occupation:_____

How did you become aware of our practice?:_____

Do you or any of your family members have or have had any of the following conditions (**please use a cross at a time – only if it applies!**):

Arthritis Me____ Familienmitglied_____

Lung diseases (asthma, bronchitis, etc.) Me____ Familienmitglied_____

Cancer Me____ Familienmitglied_____

Diabetes Me____ Familienmitglied_____

Heart disease Me____ Familienmitglied_____

High blood pressure Me_____ Familienmitglied_____

Recurrent hypoglycemia Me____ Familienmitglied_____

Kidney disease Me____ Familienmitglied_____

Depression Me____ Familienmitglied_____

Diagnosed mental illness
Me_____Familienmitglied_____

Infectious diseases (hepatitis, AIDS) Me____ Familienmitglied_____

II) Activity tolerance

2. How high do you think the probability is that you will be able to carry out your usual activities and work again within 6 months without any problems:

   Very safe 0 1 2 3 4 5 6 7 8 9 10 Not at all safe (impossible)

3. Physical activity makes my problems worse!

   Strongly disagree 0 1 2 3 4 5 6 7 8 9 10 I absolutely agree

4. Which specific daily activities cause you the most problems? Please rate the pain as 0 (no pain) to 10 (you go to the hospital voluntarily)

1:_____ Pain level:_____
2:_____ Pain Level:_____
3:_____ Pain Level:_____
4:_____ Pain Level:_____
5:_____ Pain Level:_____
6:_____ Pain Level:_____
7:_____ Pain Level:_____

Unexcused absences are a financial problem for us as professional health care providers. With my signature, I accept the regulation that I will receive an immediate unannounced cancellation invoice for unexcused, unattended and missed appointments without cancellation within 24 hours.

I hereby confirm the **accuracy and completeness of the information**. As a physiotherapy company, the Sporting Spine Company and all employees are subject to medical confidentiality regarding personal data. This duty of confidentiality applies for a lifelong time.

Name: _____ Date:_____

Your Signature:_____

Please refer to page three

Cancellation Fee Agreement

Dear Patient,

Our company operates on a scheduled appointment system. This means that the agreed appointments are reserved exclusively for you. During this time, no other patients can be treated.

If you are unable to attend an appointment, it must be cancelled at least 24 hours in advance.

If cancellation is not made in due time or if the appointment is not attended without prior notice, we reserve the right to charge a cancellation fee in the amount corresponding to the treatment scheduled for that appointment.

The fee will be calculated based on the treatment service originally planned (e.g. physiotherapy, manual therapy, etc.).

These costs are not covered by statutory or private health insurance and must be borne by the patient.

A cancellation fee will not be charged if you can provide evidence that you were unable to attend the appointment for reasons beyond your control (e.g. accident).

By signing below, I confirm that I have been informed about the cancellation policy and the potential costs in the event of non-attendance, and that I agree to these terms.

Regensburg, Date: _____

Signature: _____