

Date: _____

Personal intake 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: _____ Address: _____

Location: _____ PLZ: _____

Date of birth: _____ Insurance Co: _____

Private phone: _____

Mobile: _____

E-mail address: _____

You will automatically receive an appointment reminder via **SMS** and **E-Mail**. If you prefer not to receive appointment reminders, please indicate this by ticking the box below.

☐ I do not wish to receive appointment reminders via SMS or email.

Occupation: _____

How did you become aware of our practice?: _____

Do you or any of your family members have or have you had any of the following diseases (please tick one box for each – only if it applies!):

Arthritis Myself _____ Family member _____

Lung diseases (asthma, bronchitis, etc.) Myself _____ Family member _____

Cancer Myself _____ Family member _____

Diabetes Myself _____ Family member _____

heart disease Myself _____ Family member _____

high blood pressure Myself _____ Family member _____

Recurrent hypoglycaemia Myself _____ Family member _____

kidney disease Myself _____ Family member _____

depression Myself _____ Family member _____

Diagnosed mental illness

Myself _____ Family member _____

Infectious diseases (hepatitis, AIDS) Myself _____ Family member _____

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

3. Physical activity makes my problems worse!

Strongly disagree 0 1 2 3 4 5 6 7 8 9 10 Strongly 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: _____

Important information (Please read carefully!)

Cancellation fee

Appointments are reserved exclusively for you and must be cancelled at least **24 hours** in advance. In the event of late cancellation or a no-show, a cancellation fee equivalent to the cost of the treatment scheduled for that appointment may be charged. This fee is to be paid by the patient.

Statutory co-payment

Patients covered by statutory health insurance are generally required to pay the statutory co-payment. This amounts to 10 per cent of the treatment costs plus €10 per prescription and must be paid at the practice at the start of treatment. Children and young people up to the age of 18 are exempt from the co-payment. Exemption is only possible upon presentation of a valid exemption card.

Confirmation

I hereby confirm that the information I have provided is accurate and complete. I have been informed of the regulations regarding cancellation fees and the statutory co-payment and accept these. The Sporting Spine practice and its staff are subject to a statutory duty of confidentiality regarding my personal data. This obligation continues even after the treatment has ended.

Regensburg, date: _____

Signature