

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



Case history

Please fill out this questionnaire carefully and bring it to your first appointment.

Please put a cross by the examples if they apply, or answer in your own words.

Note: You can fill this PDF file directly on PC / Tablet / Smartphone.

However, editing in browsers (e.g. Microsoft Edge) may be faulty, so please use common PDF viewers such as Adobe Reader or the PDF X Change Viewer.

You are also welcome to print out the medical history form and fill it out by hand.

Please take enough time to complete it carefully.

Title

First name

Surname

Street

House/flat number

Postcode

Town/city

Country

Date of birth

Place of birth

Time of birth

Height/body weight

Occupation

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



Fixed line

Mobile phone

Mail

1 Complaints

What symptoms are you currently suffering from?

Please indicate the duration and intensity of the symptoms on a scale from 0 to 10.

Please write down the symptoms in order of severity.

1.	since:	Intensity (1-10):
<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	since:	Intensity (1-10):
<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	since:	Intensity (1-10):
<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	since:	Intensity (1-10):
<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	since:	Intensity (1-10):
<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	since:	Intensity (1-10):
<input type="text"/>	<input type="text"/>	<input type="text"/>
7.	since:	Intensity (1-10):
<input type="text"/>	<input type="text"/>	<input type="text"/>
8.	since:	Intensity (1-10):
<input type="text"/>	<input type="text"/>	<input type="text"/>

What therapy have you already received for these symptoms?

How many doctors/clinics/complementary therapists have you been to so far?

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



How successful was the therapy?

very good Good Moderate Poor Very Poor

What was your condition directly before your current symptom/s emerged?

A cold Sorrow Grief Fright Operation/s Skin condition/eruptions Other:

What medications/supplements are you currently taking?

Name:	Since:	Daily dose:
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Name:	Since:	Daily dose:
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Name:	Since:	Daily dose:
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Name:	Since:	Daily dose:
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Name:	Since:	Daily dose:
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Name:	Since:	Daily dose:
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Name:	Since:	Daily dose:
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Name:	Since:	Daily dose:
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Do you suffer from allergies: Yes No

If yes: to what? (Food related intolerances/allergies please in section 5)

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



What do you expect from our therapy?

2 Medical history

Chronology:

Please list all the illnesses and operations that you have undergone.

Which infectious diseases have you had?

- | | | | |
|----------------------------------|--|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Hooping cough | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Salmonella |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Polio | <input type="checkbox"/> Dysentery |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Malaria | <input type="checkbox"/> Syphilis |

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



Mononucleosis Gonorrhoea Tropical diseases Tuberculosis

Were these diseases (or others) treated with antibiotics? Yes No

If so, which were used?

Do you have scars from operations? Yes No

Do you often get colds? Yes No

What illnesses have members of your family suffered from?

<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gout
<input type="checkbox"/> Psychiatric diseases	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart diseases	<input type="checkbox"/> Dandruff
<input type="checkbox"/> Vascular diseases	<input type="checkbox"/> Neurodermatitis	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes mellitus	
<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Venereal diseases	<input type="checkbox"/> Stones	<input type="checkbox"/> Other:

3 Vaccinations

Did you received vaccinations ? If so, which ones? Yes No

<input type="checkbox"/> Cholera	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Sars-Cov-2
<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Hooping cough	<input type="checkbox"/> Pneumococci	(Corona/Covid19)
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> HPV	<input type="checkbox"/> Polio	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Flu	(Human papilloma virus)	<input type="checkbox"/> Rotavirus	<input type="checkbox"/> Tuberculosis (BCG)
<input type="checkbox"/> HiB	<input type="checkbox"/> Measles	<input type="checkbox"/> Rubella	<input type="checkbox"/> Yellow fever
(Haemophilus influenzae b)	<input type="checkbox"/> Meningococci C	<input type="checkbox"/> Smallpox	<input type="checkbox"/> Other:

Did you had reactions to vaccinations?

High temperature Cramps Anxiety Insomnia Behavioural changes

4 Emotional symptoms

Do you react to warmth in summer? Yes No

Are you sensitive to touch? Yes No

Are you affected by a closed collar? Yes No

Are you affected by a tight belt? Yes No

Do you like constricted spaces (lifts, etc.)? Yes No

Do you lack concentration? Yes No

Are you tired and exhausted? Yes No

Do you suffer from heightened irritability? Yes No

Fear/guilt feelings/conflicts? Yes No

Do you do sport regularly? Yes No

Do you sweat easily? Yes No

Do you sweat at night? Yes No

At which part of your body?:

Cold sweats Warm sweats

Do you get cold easily? Yes No

Do you get cold hands or feet easily? Yes No

How resilient and productive do you feel?

Very resilient Moderately resilient Not at all resilient

How is/was your relationship with your parents?

Very good Good Moderate Poor

Do you have a partner? Yes No

If so, how is your relationship with your partner?

Very good Good Moderate Poor

Are you happy? Yes No

5 Nutrition

How many litres do you drink a day? litres

What do you drink mostly?

What foods do you eat?

Dairy products Sweets Products made from white flour Cakes Eggs Sugar Nuts

What foods do you find it hard to do without?

Craving for foods that are:

Sweet Sour Savory Bitter Salty Spicy Meat Eggs Fruit Nicotine Alcohol

Aversion to food that are:

Sweet Sour Savory Bitter Salty Spicy Meat Eggs Fruit Nicotine Alcohol

Food allergies/intolerances to:

Do you live according to certain food guidelines? If so, which?:

Yes No

Were you breastfed?

Yes No

Did you have a natural birth?

Yes No

Are you willing to improve your nutritional habits with our assistance?

Yes No

6 House/flat

Has where you sleep and work been investigated for
geopathic stress and electromagnetic pollution?

Yes No

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



Any interference near/in your house/flat?

- | | |
|---|---|
| <input type="checkbox"/> Telegraph poles nearby | <input type="checkbox"/> Damp spots or known water damage |
| <input type="checkbox"/> Overhead cables/railway electricity nearby | <input type="checkbox"/> Antiques/wood protection agents |
| <input type="checkbox"/> Streams/rivers nearby | <input type="checkbox"/> Carpets |
| <input type="checkbox"/> Mould | <input type="checkbox"/> Microwave |

Describe the area where you sleep:

- | | |
|---|---|
| <input type="checkbox"/> Cordless phones/Internet | <input type="checkbox"/> Waterbed |
| <input type="checkbox"/> Electrical devices in standby mode | <input type="checkbox"/> Installed electric motor |

What is your sleep like?

- | | |
|--|---|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Talk in my sleep |
| <input type="checkbox"/> Wake up frequently at: <input type="text"/> o'clock | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Urinate at night. How often?: <input type="text"/> | <input type="checkbox"/> Hot feet |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Tooth grinding |
| <input type="checkbox"/> Restless legs | <input type="checkbox"/> Lively dreams |

Position when asleep

- Stomach Back Left Right Sitting Kneeling Rolled up

7 Head • Neck

Do you suffer from headaches? If so, how?:

Yes No

- | | | |
|--|---|---|
| <input type="checkbox"/> Often | <input type="checkbox"/> Evenings | <input type="checkbox"/> Right |
| <input type="checkbox"/> Seldom | <input type="checkbox"/> Mornings | <input type="checkbox"/> Wandering from left to right |
| <input type="checkbox"/> Forehead/eyes/temples | <input type="checkbox"/> On one side of the head: | <input type="checkbox"/> Wandering from right to left |
| <input type="checkbox"/> Back of the head | <input type="checkbox"/> Left | <input type="checkbox"/> Both sides |

Trigger of the headaches, if known:

What improves it?

What makes it worse?

Hair

Do you suffer from hair loss? If so: Yes No

Circular Scattered Since: Weeks Month Years

Eyes

Frequent conjunctivitis Short-sighted Far-sighted Glaucoma Cataract

Other complaints:

Glasses since (year): Dioptries:

Ears

Pain, left Frequent otitis media Ear pressure

Pain, right Hard of hearing

Both sides Noises in the ears

Teeth / jaw

Frequent visits to the dentist

Dead teeth

Teething complaints

Teeth sensitive to:

Difficultly with wisdom teeth coming through

Heat Cold Sweet Sour

Root treatment

Do you have dental fillings? If so, of which material? Yes No

Amalgam Gold Titanium Plastic Ceramic Palladium

Other:

Have amalgam fillings been removed? Yes No

Nose

Operations

Discharge:

Hay fever

Watery Mucousy

Restricted nasal breathing

Purulent Green-coloured

Blocked nose

Frequent sinusitis

Tonsils

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



Operation

Frequent tonsillitis:

As a child Nowadays

Thyroid

Known Hyperthyroid

Enlarged

Known Hypothyroid

Operation

Other:

8 Breasts • Stomach • Back

Breasts / mammary glands

Complaints Operations

Heart

Complaints

Heart attack

Angina pectoris

Stabbing pains

Anxiety

Sensation of pressure

Arrhythmia

Lungs

Bronchitis Frequent cough Shortness of breath

Liver

Inflammation Hepatitis

Gallbladder

Stones Colics Operation Pressure in the upper abdomen Fat intolerance

Stomach

Bloating Gastritis Lack of appetite Food allergies/intolerances

Back

Pain Lumbago Sciatica Scoliosis

Kidney/bladder

Kidney stones Inflammation Frequent:

Urine

A lot

Little

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



Frequent Cannot hold it

Smells of:

Intestines

Infections Appendix removed
 Haemorrhoids Bloating

Stool

Daily Every second day Irregular Tendency to constipation Tendency to diarrhea

Smells of:

Stool consistency

Light Hard Greasy Feeling of not being able
 Dark Knobbly Paste-like to fully pass stool
 Foul Smelling Soft Cannot hold stool

9 Arms • Legs • Back • Skin

Arms

Injuries Pain Tennis elbow Pins and needles Cold hands

Legs

Pain Varicose veins Operations Injuries Cold feet Pins and needles Numbness

Back

Impaired mobility Tension Strain Rheumatism

Skin/nails

Burns Itching Ingrown nails
 Scars Warts Inflammation of the nailbed
 Ulcers Fungus Allergies to:

10 Gynaecological/urological area

Gynaecological

Pain Inflamm. of the ovaries Curettage of the uterus Miscarriages

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



- Births, no.: Tumours Fibroids
 Abortions Cysts Venereal diseases

Discharge

- None Heavy White Yellow Damages the skin Discoloured underwear

Periods

When was your first period? Your last?

How long is your period? How long is your cycle?

(1 .day of your last period until the day prior to the next period e.g. 27 days)

Bleeding is

- Light Clumpy Regular
 Dark Brown Irregular

Prostate

- Enlarged Difficulties urinating
 Inflammation Venereal diseases

Sexuality

- Low libido Satisfied Dissatisfied
 High libido Fulfilled sexual life Non-fulfilled sexual life
 Difficulties during sexual intercourse

11 Radiation exposure

Do you use a mobile phone? Yes No

If so: How many minutes do you use it each day?

Each day about Minutes

Since: Month / Years. With Without headset Both

It is switched on about minutes a day / Always switched on

Where do you wear it?

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



Do you own a DECT-telephone (cordless fixed telephone)

Yes No

If so, how many minutes do you use it each day? Each day about Minutes

Since:

Month / Years. With Without headset Both

Which brand and/or model?

Do you use any wireless LAN connections ?

Yes No

If so:

How many minutes each day?

Each day about Minutes

Since: Month / Years.

It is switched on about Minutes a day / Always switched on

Railway

Distance from your house / flat to the next railway station: About km

Telephone pole / radio mast

Distance from your house / flat to the next telephone pole / radio mast or radar station? About km

Since when do you live in that distance to it? Weeks Month Years

Dr. med. Ralf Heinrich
Krimhild Korndörfer-Luft
Dr. med. Christian Becker
Dr. med. Uwe Günther
Dr. med. Ralf Hilbert

Dipl. med. Erika Schadwell
Dr.med.Heidi Schmalgemeier
Dr. med. Siegfried Schlag
Prof. Dr. Pascal Dohmen
Dr. med. Christian Bahr



12 Space for further information:

I hereby agree that my case documentation including laboratory results may be made available (in sanitised form) to other therapists and scientific institutions (voluntarily).

Date, place, signature of the patient