HEALTH ASSESSMENT FORM

General questions

Name: _____ DOB: _____

Phone: _____ Email: _____

Billing address: _____

Weight: _____kg Height: _____cm

Why are you visiting me (Current problems: what is it, where is it located, how long ago):

_____

_____

_____

What do you expect from the treatment: _____

_____

_____

How did you find me? _____

1.Do you have any chronic illness/sickness Yes No

If yes, than state it, please:

_____

Do you have any disorders or diseases of the following organ structures? Heart ( ), lungs ( ), gastrointestinal tract ( ), pancreas ( ), liver/bile ( ), kidney ( ), bladder ( ), prostate/uterus ( ), nervous system ( ): Sense organs: ear ( ), eye ( )?_____

2. Are you currently undergoing medical treatment? Yes No

3. Are you currently taking any medication, vitamins, hormones? Yes No

If yes, please write down the name of the medicine, hormone, vitamin, and what you are taking it for?_____

If you are taking medication - Have you taken your medication today? Yes No

4. Have you had surgery? Yes No

If yes, then when? within: 3-6 weeks 3-6 months 1-2 year over than 5 years

What kind of surgery was it? _____

Were there any complications and/or complaints, if so, what were they?

_____

5. Do you have any allergies? Yes No
If yes, then what?_____

6. Are you aware of a blood pressure problem or heart disease? Yes No

If yes, then what?_____

7. How much water/liquid do you drink?
1-2 liters per day ( ) 2-3 liters per day ( ) More than 3 liters per day ( )
Less than 1 liter per day ( )

8. Eating habits: breakfast, lunch, dinner, any other meals. What and when? If irregular, then what and when? _____

_____

9. Consumption of the following: Coffee, tobacco, alcohol, tea, etc. When, how often and what? _____

10. Do you have a urinating problem? E.g. pain, too often maybe bladder or kidney inflammation? _____

11. Do you have any problems with passing stool? E.g.: constipation, diarrhea, bleeding?

_____

12. Do you go for regular screening? _____

13. Sleeping habits: • normal • has difficulty falling asleep • increased need for sleep • somnolent • decreased need for sleep • disrupted sleeps • only with medication

14. Please select the statements that are true for you: sleep disorder ( ), concentration disorder ( ), reduced performance ( ), irritation ( ), feeling of anxiety ( ), mood swings ( ), overload ( ), restlessness ( ), other: _____

15. Do you exercise regularly? Yes ( ) Occasionally ( ) No ( )
If so/infrequently, then how regularly and what?_____

16. Are you usually feeling cold or hot? _____

17. Skin abnormalities: birthmark, verruca, rashes, itching, wart, rash, itching, peeling, etc: _

Questions related to childhood

18. Any abnormal reaction to vaccines?_____

19. Infectious childhood diseases? Were there any, how did they go?_____
_____

20. Did you have any recurring childhood diseases, e.g.: otitis, tonsillitis, bronchitis, pneumonia: _____

Questions for the Ladies

21. How do you prevent pregnancy?_____
22. Do you have any issues throughout your period? _____
Period frequency, length, color, texture, accompanying symptoms (cramps, breast pain, headache, etc.) _____
23. Did you have any pregnancies, if yes, when? _____
24. Did you give birth? If yes, when? _____
25. Were there any complications during pregnancy, giving birth and/or after? _____
_____
26. Do you have menopause complaints? If so, what are they? _____
_____

Questions about family related issues

27. Are there any special, hereditary diseases or health problems in your family? Among parents, grandparents, aunts/uncles, siblings, children. E.g. high blood pressure, diabetes, heart attack, allergy, eczema, gout, tumor, premature death: _____
_____
_____

Questions about your current health issues

28. Are there external factors that alleviate or increase your complaints? Movement ( ), rest ( ), heat ( ), cold ( ), sitting ( ), lying ( ), running ( ), standing ( ), straightening ( ), bending ( ), turning ( ), wearing shoes ( ), lifting ( ), cough ( ), pressure ( ), wind ( ), weather ( ), other:_____

29. Rate your pain on a scale of 0-10: _____

30. What is the nature of your pain: stabbing ( ), ripping ( ), sharp ( ), tearing ( ), shooting ( ), burning( ), spastic ( ), dull ( ), radiating ( ), if so, where: _____

other: _____

31. How often do you notice your complaints and pain?

Rarely ( ), occasionally ( ), often ( ), at rest ( ), always ( ), during exercise ( ),

Can you related any time of day?_____ Any body position: _____

Other?_____

32. Have you noticed any symptoms of numbness ( ), weakness ( ), lack of coordination ( ), paresthesia ( ), tingling ( ), burning ( ), skin area or body part hypersensitivity ( )?_____

33. Have you seen a doctor with your problem(s)? If so, what treatment was used by?

_____

Has your complaint caused a change in your lifestyle? If so, how has it changed? _____

_____

With my signature, I confirm that I am aware that Andrea Cseresznyés is not a doctor, but a naturopath, so she does not establish a diagnosis, does not modify the prescribed drug treatment, and treats my symptoms and illnesses only based on the medical diagnosis established and supported by a doctor. If I do not have a diagnosis, I must consult the appropriate specialist or my general practitioner on the recommendation of the therapist. During my care, only naturopathic methods are used that support the body's self-healing mechanisms. I have received adequate information about the naturopathy service(s) I wish to use, and I use the treatment and consultation knowing this.

My signature applies to the therapies marked with an "X" below:

Personalized Movement Massage TherapyTreatments (full body treatments: FDM, Chiropractic, Sports and therapeutic massage, Manual therapy procedures->Maitland-, Mulligan-, Dorn Method, Body-, Ear Candles, Moxa Therapy, Breuss massage, as well as facial, head, foot massages): General physical well-being-improving treatment, which I take at my own risk with the pre-agreed frequency and duration. This is intended to maintain and improve the load-bearing capacity of tired muscles for the body part(s) of my choice. It does not replace the movement required in everyday life. In the case of reduced range of motion, I acknowledge that, for the sake of my development, he may recommend an additional specialist or another colleague for my treatment, even as a supplement, and I will use that, otherwise he may refuse my further care.

Personal and Group Gymnastics: I only perform this type of treatment with the frequency and duration recommended by the therapist. If it is not recommended for me after the consultation, I will take note of that.

Lymphatic massage (lymphatic drainage): a special type of massage that improves lymphatic drainage; its regular use eliminates tissue lymph stagnation, activates the immune system, stimulates the removal of waste materials, thus contributes to the regeneration of cells and tissues, reduces the propensity for inflammation, and promotes the healing of existing inflammations and wounds.

Holistic Pulsing - Soul massage: A manual therapeutic procedure designed to support physical, mental and spiritual harmony and freshness. It does not replace any medical treatment or medication. In case of any changes in my well-being or side effects after the treatment, I will inform the therapist immediately, but no later than 72 hours after the therapy. If I fail to do this or if I take part in other therapy that worsens the effect of the treatment, I try to alleviate it with mind-altering drugs, then my further care may be refused.

Bach flower therapy: Based on the described mental and emotional state, a personalized essence mixture is compiled, which must be applied internally. The essences have no physical side effects, they cannot be

overdosed, and they do not affect the effects of the drugs, nor do the drugs affect the effects of the essences. In the case of the combined use of certain high-potential homeopathic remedies, it may arise that it is not possible to identify whether the desired result was achieved through the homeopathic remedy(s) or the Bach essences, so their parallel use is not advisable. I am aware that the method can only be effective if the prescribed amount and frequency of intake are observed. I accept that there may be an initial worsening or improvement at the beginning of taking the mixture, which will disappear after a few days. I was informed that the Bach flower therapy treatment does not replace a medical examination, nor the necessary treatment or medication.

Consultation: Analysis of medical records and based on recommended methods,such as phytotherapy procedures, and recommended elements of alternative medicine are included. I am aware that it can only be effective if the prescribed amount and/or frequency of intake is observed. I accept that there may be an initial worsening or improvement, which will disappear after a few days. I was informed that the agreed treatment does not replace a medical examination, nor the necessary additional treatment or medication.

I undertake that I will inform you of my intention to change the booked appointment no later than 24 hours before the actual appointment. Otherwise, I agree to pay the honorarium/handling fee as a cancellation fee at the time of late cancellation.
I understand that my therapist will not start treatment under the influence of mind-altering substances (alcohol, drugs, etc.). If this is revealed personally when I show up at the appointment, I am obliged to pay the full treatment fee immediately and leave.
I have been informed that my personal data will be treated confidentially by my therapist and will only be disclosed to third parties in the cases provided for in the legal regulations in force at all times - e.g. authority authorized to do so - provided.

I declare that the data I provide is the reality and I use the therapy at my own risk.

In the case of a child client, I sign this declaration as a parent (or carer, guardian).

Date:_____

_____
Signature

PRIVACY POLICY
GDPR Statement

Based on Article 13 of the EU General Data Protection Regulation (Regulation No. 679/2016, hereinafter: GDPR), I provide the following mandatory information:
Name of entrepreneur/enterprise: Corpus Vitae - Testműhely (Andrea Cseresznyés owner)
Tax number: 57215860-1-29; Headquarters: 4028 Debrecen, Kassai út 129. II/211.
Contact: Tel.: +36702696187; +3652256757; https://corpusvitae.hu; info@corpusvitae.hu; https://corpusvitaetm.booked4.us; https://facebook.com/corpusvitaetm; https://instagram.com/corpusvitaetm; https://youtube.com/corpusvitaetestmuhely; https://tiktok.com/corpusvitae.

Data protection officer: Andrea Cseresznyés

Data protection requests: if you have questions about data management, you can send your request by post to the address and name indicated above. I will send my answer to the address you requested without delay, but within 30 days at most. You can also ask your questions in person. Data processing: By hand
Foreign data transfer: no transfer takes place abroad.
The data management of my company's activities are based on voluntary consent and legal authorization. In the case of data processing based on voluntary consent, the data subjects may withdraw their consent at any stage of the data processing.
Due to the issue of invoices, the management, storage and transmission of data is governed by legislation
mandatory.
The processing of the personal data (first name, telephone number) of a child under the age of 16 is legal if the consent was given by the person exercising parental supervision over the child, or permitted. GDPR Article 8, (1), (2) It is enough to give consent before the first treatment.
Data management purposes
In connection with the provision of other services that improve health and physical well-being, I process the data of service users for the purpose of fulfilling legal obligations and maintaining customer relations
Legal basis for the use of your personal data
The use of your personal data - name, address (tax number in case of verification) - for it is necessary for me to be able to issue an invoice in accordance with the accounting legislation, if you request it
in connection with the provision of the service. Legal basis: GDPR Article 6 (1) point c).
b) Your phone number, email address and first name are only required for the purpose of making an appointment. Legal basis: GDPR Article 6 (1) point a) You give your consent by entering your phone number, email address and first name. If you do not enter these, you will not be able to use the service.
Location, duration and transmission of data
Due to legal obligation, I keep the invoices at my registered office for at least eight years; data is forwarded to NAV, you will receive an invoice when using the services.
b) The data provided for the purpose of contact (first name, phone number, email address),

which I keep in my electronic deadline diary and which I always have, I will delete/destroy one year after our last meeting, or I will delete it immediately upon request; no data transfer takes place.
c) The information provided on Facebook, Instagram, TikTok, YouTube, website, email and/or telephone is present until the relationship exists; no data transfer takes place.

Affected rights (your rights)
access to the data I manage about you; you can exercise your right to data portability
if a data is outdated or incorrect, its adjustment;
deletion of the data I manage about you, this right applies only to contact data;
restriction of data processing;
prohibiting the use of your personal data for direct marketing purposes;
the transfer of your personal data to a third-party service provider, or to this prohibition;
providing a copy of any personal data I manage about you;
objection to the use of personal data by me.

Remedial information
National Data Protection and Freedom of Information Authority (1125 Budapest, Szilágyi Erzsébet fasor 22/C) Mailing address: 1530 Budapest, Pf:5. Phone: +3613911400 Fax: +3613911410 Email: ugyfelszolgalat@naih.hu Website: http://www.naih.hu

My company reserves the right to change this information at any time, should there be a change in the decree, law, or company data. If the change affects information that requires you to be notified, I will do so immediately.
I would like to inform you that the court, the prosecutor, the investigative authority, the infringement authority, the public administrative authority, the National Data Protection and Freedom of Information Authority, the Magyar Nemzeti Bank, or other bodies based on the authorization of the law, provide information, communicate data, transfer documents, or in order to make it available, you can contact the
my business as a data controller. If the authority has specified the exact purpose and scope of the data, my company only discloses personal data to the authorities to the extent and to the extent that is absolutely necessary to fulfill the purpose of the request.
You may share health information with me as a result of the service. No other person can get to know this information.

I have understand and/or taken note of the information:

Debrecen, 202_____ _____ Signature