Ananmesis questionnaire 0 - 24 months
Please fill in and bring to the appointment.

Name: ________________________________ Date of birth: _________________________

Peculiarities during pregnancy (e.g. bleeding, premature labour, ...)

Peculiarities during birth (e.g., lateral, BEL, suction cup, section, umbilical cord around neck, ...)

Other conspicuousness (please tick)

	very noticeable	noticeable	less noticeable	inconspicuous	I don't know
Sleep					
Breastfeeding / drinking					
Screaming / cal-ming					
Bowel move-ment					
Mood					
Spitting					
Nervousness					

Previous therapies: e.g. osteopathy, physiotherapy (when?): ________________________

Other health problems, medication: ____

Last vaccination: ____

Name of the pediatrician: ____

Has a sibling child been treated here before? yes / no Name: __________________

Date: _____________________________ Signature: __________________________