**Praxis Kessler**
Eppendorfer Weg 132, 20253 Hamburg | +49 40 4309 1820 | hallo@praxis-kessler.de
praxis-kessler.de



# Patient details and appointment

Please review the contact details and tell us how to reach you before and after the first appointment.

## Form fields

PATIENT ID

DATE OF BIRTH

ADDRESS

PHONE

EMAIL

INSURANCE

EMERGENCY CONTACT

PREFERRED LANGUAGE

## Appointment preparation

- [ ] I can attend in person at the Hamburg practice.
- [ ] I consent to appointment reminders by SMS.
- [ ] I would like invoices sent through the patient portal.
- [ ] I need barrier-free access support.

## Reason for visit

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# Symptoms and health background

This page helps Nora Kessler understand the pattern, timing, and prior workup behind the main concerns.

## Form fields

MAIN SYMPTOM DURATION

CURRENT GP

KNOWN DIAGNOSES

RECENT TESTS

PREGNANCY STATUS

ALLERGIES

## Symptoms reported in the last 30 days

- [ ] Digestive discomfort after meals
- [ ] Headaches or migraine episodes
- [ ] Sleep disruption
- [ ] Unplanned weight change
- [ ] Chest pain or fainting
- [ ] New neurological symptoms

## Patient context

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# Medication, supplements, and lifestyle

Please list everything taken regularly so the practitioner can screen for interactions and avoid duplicated recommendations.

## Form fields

CURRENT MEDICATION

SUPPLEMENTS

DIET PATTERN

CAFFEINE

ALCOHOL

EXERCISE

SLEEP

STRESS LEVEL

## Care preferences

- [ ] I prefer gentle stepwise changes over strict protocols.
- [ ] I am open to nutrition tracking for two weeks.
- [ ] I am open to herbal recommendations.
- [ ] I currently use anticoagulant medication.

## Patient goals

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# Consent and signatures

The intake form is not a diagnosis. Urgent symptoms should be assessed by emergency or conventional medical services.

## Form fields

CONSENT VERSION

FORM STATUS

SUBMITTED

PRACTITIONER

## Patient acknowledgements

- [ ] The information provided is accurate to the best of my knowledge.
- [ ] I understand naturopathic care may complement but not replace medical care.
- [ ] I consent to secure storage in circleOS.
- [ ] I consent to sharing this intake with external providers automatically.

## Signatures

PATIENT SIGNATURE | NAME | DATE

PRACTICE REVIEW | NAME | DATE