Dr. Christine Siepe
TFN: 888 773 3196
https://true-pathfinder.com/

Please fill in the form as correct as possible according to your best knowledge. All information is treated with the highest confidentiality and privacy. This info will not be disclosed to a third party, published, or sold. By signing this form, you agreed to be tested and treated by our doctors and you freely submitted all necessary information.

Anamneses Sheet

Family Name:	**First Name:**
Phone:	**Email:**
Street Address:	
City:	**Postal Code:**
Birth Date/Time (YY/MM/DD) :	
Profession:	
Social Situation: ☐ Single ☐ Partnership ☐ Family	
Profession Description: ☐ Physical ☐ Mental ☐ Outside ☐ Sitting ☐ Standing ☐ In House	
Profession Satisfaction: ☐ Satisfied ☐ Unsatisfied	
Sports Activities: ☐ None ☐ Sometimes ☐ Regularly	
Type of Sports:	
Body Weaknesses and Injuries:	

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Compensation Activities/Hobbies:

Diseases / Symptoms / Main Concern:
Please add any Clinical reports, Blood- and tests Reports, X-Ray pictures, or similar

Organ Systems:

- ☐ Heart-Blood Circulation
- ☐ Heart Pacer
- ☐ Respiratory System
- ☐ Nose-Throat-Ears (ETN)
- ☐ Jaw-Teeth
- ☐ Skin
- ☐ Eyes
- ☐ Liver
- ☐ Gallbladder
- ☐ Stomach
- ☐ Pancreas
- ☐ Small intestine
- ☐ Large intestine

Minerals (which):
Please list:

☐ Never ☐ Sometimes ☐ Regularly

Vitamins (which):
Please list:

☐ Never ☐ Sometimes ☐ Regularly

Intake Any Other Drugs & Remedies:
Please list:

☐ Never ☐ Sometimes ☐ Regularly

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Any Dietary Supplements (which):
Please list:

☐ Never ☐ Sometimes ☐ Regularly

Intolerance & Allergies:

☐ Food ☐ Drinks ☐ Nuts ☐ Meats

List Details:

Inside Home Allergens? ☐ Yes ☐ No

List Details:

Outside Home Allergens? ☐ Yes ☐ No

List Details:

Any Other Details?

Environmental Influences (Geopathic Stress):

☐ Noise ☐ Electro-Smog ☐ Other

If “Other” Please List:

Children ☐ Yes ☐ No Number:	**Pregnancy** ☐ Yes ☐ No Number:
Live Births ☐ Yes ☐ No Number:	**Abortions** ☐ Yes ☐ No Number:

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Menstruation:

☐ Bleeding Strong (Flooding) ☐ Bleeding Weak ☐ Long Lasting

☐ PMS ☐ Painful ☐ Menopause ☐ Andropause

Other Details (Please List):

Surgeries in your life:	**Difficult Diseases in your life:**

Most Frequent Health Issues in Your Life:

All Supplements and Medication During last 12 Months:

All Therapies During Last 12 Months & Results You Got:

Please list all your symptoms, pain, impairments, major and minor ailments?

How do you sense these symptoms, pain: pressure, pulsating, choking, pounding, cutting, etc. Please provide a good description if possible, with visualization and imaging as best as you can.

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Where do you feel these symptoms/pain; are these radiating and, if yes where?

If worsening occurs which are the factors aggravating the symptoms/pain?

Examples: Movement, lie down, pressure, a temperature higher or lower than usual, storms, weather changes, water contact, specific time of the day, during sleep, seasonal, light or excessive sunshine, when eating, when excreting, when menstruating, nervous, stress, dispute, grief, anxiety, worries, full moon.

Same question regarding when you feel better and your symptoms are softening.

Were you already consulting with: (check all that apply)

☐ Family Physician ☐ Naturopathic Doctor ☐ Medical Doctor

☐ Specialist ☐ Homeopathic Doctor ☐ Quantum Energy Doctor

☐ Family Physician ☐ EDS ☐ Bioresonance

☐ Radionic Doctor

List Details:

Prescription Drugs Used? ☐ Yes ☐ No

Please List:

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Do you think your health issues may be caused by your psycho-mental state of mind?

☐ Yes ☐ No

If yes, please describe:

Do you have also some other "minor ailments", temporary or softly disturbing you?

☐ Yes ☐ No

If yes, please describe:

Which are the diseases you had in the past, which manifested in an acute way, and which healing easily?

☐ Yes ☐ No

If yes, please describe:

Did you have in your childhood recurrent health conditions?

☐ Yes ☐ No

If yes, please describe:

How many and if possible, which vaccines did you get, and which was your reaction thereafter, any special symptoms?

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How many and if possible, which vaccines did you get. **Was there any reaction thereafter, any special symptoms?**
Which other diseases, surgeries, special conditions, and therapies did you have and when?
Have you noticed any skin changes, eczemas, which kind, and when? **Were these treated, which therapies were applied?**
Do you feel cold or heat more than average? **Do you take your shower warm or cold?**
Are you a thirsty person or not? ☐ Yes ☐ No **Do you prefer to drink warm or cold liquids?** ☐ Warm ☐ Cold **Which are your preferred drinks and food?**

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Do you sometimes want some specific food and drinks, but you are having incompatibility or adverse reactions (such as allergies, nausea, vomiting, diarrhea, etc.) when consuming them?

☐ Yes ☐ No

List Details:

Do you prefer saltier foods? ☐ Yes ☐ No

Do you try to avoid salt? ☐ Yes ☐ No

Do you prefer sugar (sweet) foods? ☐ Yes ☐ No

Do you try to avoid sugar? ☐ Yes ☐ No

How often do you consume sweet foods?

Do you prefer fattier foods? ☐ Yes ☐ No

Do you try to avoid fats? ☐ Yes ☐ No

Do you sweat much? ☐ Yes ☐ No

Which body zones do you experience sweat? Please list:

Do you see or feel any special reactions or symptoms when excreting stool, urine, period bleeding, sweating?

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Do you have anxiety, fears, panic when thunderstorms are occurring, claustrophobia, height fear, small rooms, public speaking, or performing?
Do you dream often, and do you see repeatedly dreams; which are your dreams, do you remember these?
Which are now your major health concerns and targets?

Date/Place _____

Your Signature _____