



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.**

### Anamneses Sheet

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



**Compensation Activities/Hobbies:**

**Diseases / Symptoms / Main Concern:**

Please add any Clinical reports, Blood- and tests Reports, X-Ray pictures, or similar

**Organ Systems:**

- |  |   |
|--|---|
| <input type="checkbox"/> Heart-Blood Circulation | <input type="checkbox"/> Heart Pacer            |
| <input type="checkbox"/> Respiratory System      | <input type="checkbox"/> Nose-Throat-Ears (ETN) |
| <input type="checkbox"/> Jaw-Teeth               | <input type="checkbox"/> Skin                   |
| <input type="checkbox"/> Eyes                    | <input type="checkbox"/> Liver                  |
| <input type="checkbox"/> Gallbladder             | <input type="checkbox"/> Stomach                |
| <input type="checkbox"/> Pancreas                | <input type="checkbox"/> Small intestine        |
| <input type="checkbox"/> 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



**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)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Family Physician | <input type="checkbox"/> Naturopathic Doctor | <input type="checkbox"/> Medical Doctor        |
| <input type="checkbox"/> Specialist       | <input type="checkbox"/> Homeopathic Doctor  | <input type="checkbox"/> Quantum Energy Doctor |
| <input type="checkbox"/> Family Physician | <input type="checkbox"/> EDS                 | <input type="checkbox"/> Bioresonance          |
| <input type="checkbox"/> Radionic Doctor  |  |  |

List Details:

**Prescription Drugs Used?**     Yes     No

Please List:



**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?**



**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?**



**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 \_\_\_\_\_