The Root of Motion  Client Information  Today's Date:

Name:  Date of Birth:

Daytime number:  Email:

Perferred way to contact you:  Call/Text/Email  Emergency Contact:

Address:  Days that work best for appointments:

Who may I thank for your referral, or how did you hear about me?

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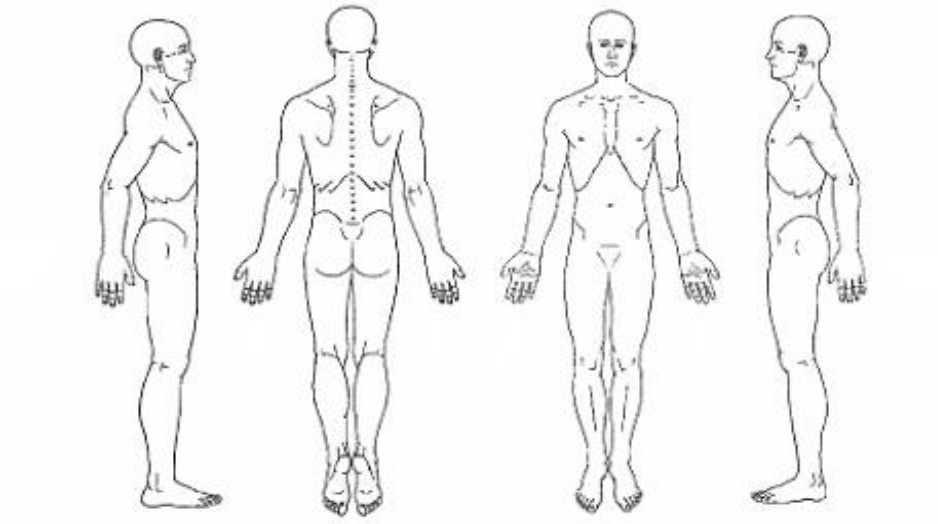
Please answer each question carefully and completely.

This is the foundation for our treatments and will assist us in making the most of our time.
If you have any questions while filling this out or anytime, please do not hesitate to call me (314) 623-7365 or email me at therootofmotion@gmail.com

**On the images below, please show where you are experiencing issues.**



**Please complete the following chart as fully as you can regarding injury and surgery past.**

| Body Part | Injuries/Trauma/Surgery | Year and Age |
|---|---|---|
| Head/ Jaw<br>(i.e. clicking jaw, TMJ concussion) | | |
| Cervical Spine/Neck<br>(i.e. whiplash, diagnosis) | | |
| Shoulder: rotator cuff/ impingement/ overuse | | |
| Wrist or hand | | |
| Trunk and Mid-Spine<br><br>(Ribs/Abdominals/Hernia) | | |
| Lumbar/ Low back | | |
| Pelvis/SI Joint/Hips/Femur | | |
| Knees/Lower legs/Ankles | | |
| Feet<br>(orthoics/toes/arches) | | |

For optimal treatments can you include the areas you want us to focus on in an order of importance.

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*
*

What are the symptoms you are experiencing currently in the areas above?
You may use the body diagram or the back of this sheet if needed.

When are discomfort or other symptoms (i.e. pain, tightness, popping, aches) more noticeable?
(i.e. in the morning, evening, with or without activity, or during)

What physical activities or motions increase your pain or discomfort?
(i.e. going up the stairs, sitting down, reaching up)

What have your tried to relieve your symptoms?
(i.e. sitting or laying down, using ice, pain medication, massage)

Explain what other forms of care and treatment have you sought out to address this issue(s)?
(i.e. Chiropractic, massages, soaks, meds)

When was your last session of bodywork?
(i.e. Chiropractor, massage, accupunture)

Explain what is your current fitness or conditioning routine.
Please be specific with tyes of activities and daily, and weekly details.

Breifly discuss what you used to do when you started being active.
For instance, basic exercise or competitive athletics, weekend out or daily)

Please share any specific fitness related goals.
(i.e. planned race or activity, to enjoy an activity with more ease or something new.

What would be keys indicators for you, short term, to notice your situation is improving?

What is your current activity in your occupation?

Has this changed recently?

What is your current level of stress? 1 2 3 4 5 6 7 8 9 10

What do you do to relieve stress?

Explain the quality of your sleep and which position you tend to sleep best?
(Specifically do you use sleep aids, pillows, which side/back/ stomach)

Have you been involved in a motor vehicle accident?
Please include any details from the accident such as injuries and treatments.

If you have given birth to any children, how many children and were any of the births Cesarean?

Are you currently under the care of a physician, PT, or another health care professional(s)?
If so, could you share your current care plan?

| | | | |
|---|---|---|---|
| *Ruputured Disc(s) | *Diabetes Type 1 | *Lupus | *Brain Injury |
| *Bulging Disc(s) | *Diabetes Type 2 | *Crohn's Disease | *Stroke |
| *Spinal Stenosis | *Neuropathy | *Chronic Fatique | *TMJ Disorder |
| *Nerve Impingement | *Rheumatoid Arthriti | *Eating Disorder | *Asthma |
| *Numbness in Extremities | *Fibromyalgia | *Hemophilia | *Hypertension |
| *Spondylolisthesis | *ANY AutoImmune | *Chronic Headaches | *High Cholesterol |

Please circle any of the following conditions that you have or had in the past.

Please elaborate:

The following information completes picture of your health for your treatments.
You are not required to disclose but is it helpful for me to be aware.

Medications and Supplements:

Please include any additional information regarding your health on the back side of this sheet.
Contact information of Doctors or Specialists you may want me to have for collaboration.
Results from scans or prognosis from Doctor visits.

Thank you for your time and sharing the needed information with me, I will honor your privacy.
All information provided will assist me in providing the best treatments for you and understand all that you are bringing to the table.

I have stated all the needed information at this time and should some changes in my health occur that would affect my treatments I will notify Rachael Durnell.

Client Signature: Date:_____

Rachael A. Durnell:_____ Date:_____