Today's Date _____/_____/_____

Name _____ Gender: M F DOB (M/D/Y) ____/____/____

Age ____ Email _____

Mailing Address _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell (_____)_____-_____

Emergency Contact Person _____ Phone (_____) ____-_____

THANK YOU FOR TAKING TIME TO COMPLETE THIS QUESTIONNAIRE. Please answer each question carefully and completely. This is very important information and will contribute significantly to the development and implementation of your neuromuscular and biomechanical restoration. Although some questions may seem odd, we recognize that all parts of the body and mind are one integrated and interconnected system. If you have any questions please do not hesitate to contact us.

***PART 1 – Medical History***

1. Who are your primary and secondary care medical providers? (Family physician, OBGYN, internist, psychiatrist, chiropractor, etc.) Please include full name, address and reason for seeing the provider.

| **Name** | **Address and Phone** | **Care Provided** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

2. Please list any medications you are currently taking. (Use reverse side of page if needed)

3. Do you take ***any*** nutritional/dietary supplements? If so please list below.

| Name of Supplement | Dosage | Why & How long have you been taking this supplement? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

4. Do you now have or in the past suffered from any of the following? :

| | YES | NO |
|---|---|---|
| a. Has your Doctor said or do you have a history of heart problems, chest pain or stroke | | |
| b. Has an immediate family member (parent/sibling) had a heart attack, stroke or cardiovascular disease before the age of 55 yrs old? | | |
| c. Do you frequently have pains in your heart and/or chest when you do physical activity? | | |
| d. Do you lose balance because of dizziness or do you ever lose consciousness? | | |
| e. Is our doctor(s) currently prescribing drugs for blood pressure or heart condition? See Quest #2 | | |
| f. Are you over the age of 65 and not accustomed to vigorous exercise? | | |
| g. High Cholesterol or HDL:LDL imbalance | | |
| h. Do you currently smoke? Cigarette, cigar, pipe smoking How Much How Long | | |
| i. Obesity | | |
| j. Asthma or Breathing trouble | | |
| k. Have you ever had a stroke or heart attack? | | |
| l. Are you a male greater than 45 yrs old? Are you a female greater than 55 yrs old? | | |
| m. (Females) Pregnancy currently or within last 12 months | | |
| How many children have you had? | | |
| n. Learning disabilities or cognitive challenges | | |
| o. Is there any reason not mentioned thus far to preclude you from regular exercise activity? | | |

Please elaborate here if you checked “yes” for letters a, c, d, j, n, and o.

_____
_____
_____
_____

5. Please provide your most recent blood panel and any radiological reports you may have from x-rays or MRI’s (if available).

6. Trauma/Injury/Surgery History (Starting from your earliest memory) include even what you might consider minor, non-medically treated injuries.

***Please complete the following information as completely and thoroughly as possible (note the injury/issue/surgery and the date or date range it falls in). This is an extremely important section of this questionnaire.***

| ***Body Part*** | 1-18 years | 19 - 29 years | 30 – 45 years | 46 - 60 years | 60 + years |
|---|---|---|---|---|---|
| Head/Jaw i.e. Clicking jaw, concussion, etc. | | | | | |
| Cervical/ Neck i.e. whiplash, stiffness, etc. | | | | | |
| Thoracic/ Mid back | | | | | |
| Lumbar/ Low back | | | | | |
| Ribs | | | | | |

| ***Body Part*** | 1 -18 years | 19 - 29 years | 30 – 45 years | 46 - 60 years | 60 + years |
|---|---|---|---|---|---|
| Abdomen i.e. hernia, c-section, etc. | | | | | |
| Pelvis | | | | | |
| Shoulder/ Scapulae/ Rotator cuff | | | | | |
| Elbow i.e. tennis elbow | | | | | |
| Wrist/hand | | | | | |
| Knees | | | | | |
| Ankles/Feet Do you wear Orthotics? | | | | | |

7. Have you had any cosmetic/plastic surgery? Please describe below.

_____

_____

_____

| **8. *Diagnosed Diseases*** **Please Provide all medical reports (X-rays/MRI/CT Scan)** | ***Initial Diagnosis Made*** |
|---|---|
| Orthopedic (i.e. Spinal fusion, Knee joint replacement) | |
| | |
| | |
| | |
| | |
| | |
| Metabolic (i.e. Diabetes, Hypothyroid) | |
| | |
| | |
| | |
| | |
| Neurological (i.e. Stroke, Parkinson's) | |
| | |
| | |
| Dental Work (Braces/Night Bite Plates, Appliances) | |
| | |
| | |
| | |

| 9. What is your Occupation? | How Long Under this Stressor? |
|---|---|
| Physical - Sitting, Standing, Positional | |
| Emotional - Hi Pressure, Boring, Intermittently Hi & Lo Pressure | |

10***. Please prioritize the severity (#1 is the worst or greatest concern) of your current physical pain/discomfort***

| | |
|---|---|
| #1 | |
| #2 | |
| #3 | |
| #4 | |

11. Please underline all of the following that apply to you - if any:

| | |
|---|---|
| I don't deserve love | I am worthless or inadequate |
| I am shameful | I am not loveable |
| I am not good enough | I cannot trust my judgment |
| I cannot succeed | I am not in control |
| I am weak | I cannot protect myself |
| I am insignificant (unimportant) | I am a disappointment |
| I cannot get what I want | I am a failure (will fail) |
| I have to be perfect to please everyone | I am ugly (my body is hateful) |
| I did something wrong | I am in danger |
| I cannot trust anyone | I cannot let it out |
| I do not deserve | I am angry |

12. If you feel that you are experiencing unusual levels of stress in one or more of the following areas Please circle "Yes", if not circle "No":

| | | |
|---|---|---|
| Home | Yes | No |
| Work | Yes | No |
| Financial | Yes | No |
| Relational | Yes | No |

13. Please describe a typical day of activity for you.

Example*: "My morning Starts at 6:00 am and I drink a cup of coffee and drive to work. I sit at a desk until noon and order lunch from a local restaurant. I typically work through lunch. I sit at a computer and talk on the phone and end my work day at 6pm. I drive home, pick up my kids and eat dinner around 7pm. I do house chores and am in bed by 11pm."*

14. Please describe your shoe wear. What do you wear the most throughout the week?

15. What physical activities and/or physical positions can you not perform? (I.e. kneeling down, reaching overhead)

16. What self-care strategies do you currently use to manage your own health and why? (Ice packs, stretching, acupuncture, magnets, heating pad, massage, etc.)

17. Please include any additional comments or concerns you may have (use back if needed)?

***PART 2 – Fitness and Wellness***

1. Have you consulted with a physician regarding diet and exercise? If yes, please describe the recommendations.

2. Have you in the past, or are you currently following a special diet or eating program? Please describe.

3. What if any, changes would you like to make to your current eating habits?

***If you are currently exercising please answer questions 4 through 10.***

4. Please list and rate the goals for your movement/exercise program as far as how close or far you are from reaching them right now; Circle a number for each goal listed.

| **Your Goals** | **Far** | | | | **halfway** | | | | | **Done** |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

5. Please describe your current exercise program. Include:
   How often -
   How long each session -
   Type of exercise -
   Where you exercise -

6. How long have you participated in regular exercise programs?

7. Rate your perception (circle) of the overall effort of your program? (1 – 'really easy' to 10 – 'really hard')

1 2 3 4 5 6 7 8 9 10

8. Please rate your exercise participation for each age range through to present age (1 'rarely' to 10 'a lot')

15 - 20 _____ 21 - 30 _____ 31 - 40 _____ 41 - 50 _____ 51 -60 _____ 60+ _____

9. Were you a high school or college athlete? Please list sports and positions

10. What are your favorite activities?

11. Are there any of these activities that you cannot currently do? Why not, and for how long have you been unable to participate?

12. Do you see yourself participating in your favorite activities for the rest of your life? If not, how much longer would be acceptable, i.e. when do you plan to stop participating?

13. What is your idea of a good adventure?

14. What prevents you from going on adventures?

15. Are there any activities or exercises that you do not like?

16. How much time do you have to each week to engage in the activities that you enjoy?

17. Are there any other physical issues that you have noticed that just won't go away?

18. What is your understanding of the cause of your pain?

19. What does your medical professional recommend that you do?

20. Is there anything that your medical team has recommended that you are unwilling to do? If so, why?

21. Do you have poor energy and stamina? **YES** **NO**

22. Do you have poor memory and concentration? **YES** **NO**

23. Would you describe yourself as having poor mood? **YES** **NO**

24. Do you consistently have poor sleep habits? **YES** **NO**

25. Do you have poor digestion and bowel movements? **YES** **NO**

26. Would you describe yourself as having poor strength? **YES** **NO**

27. Do you have weak bones, teeth, hair and nails? **YES** **NO**

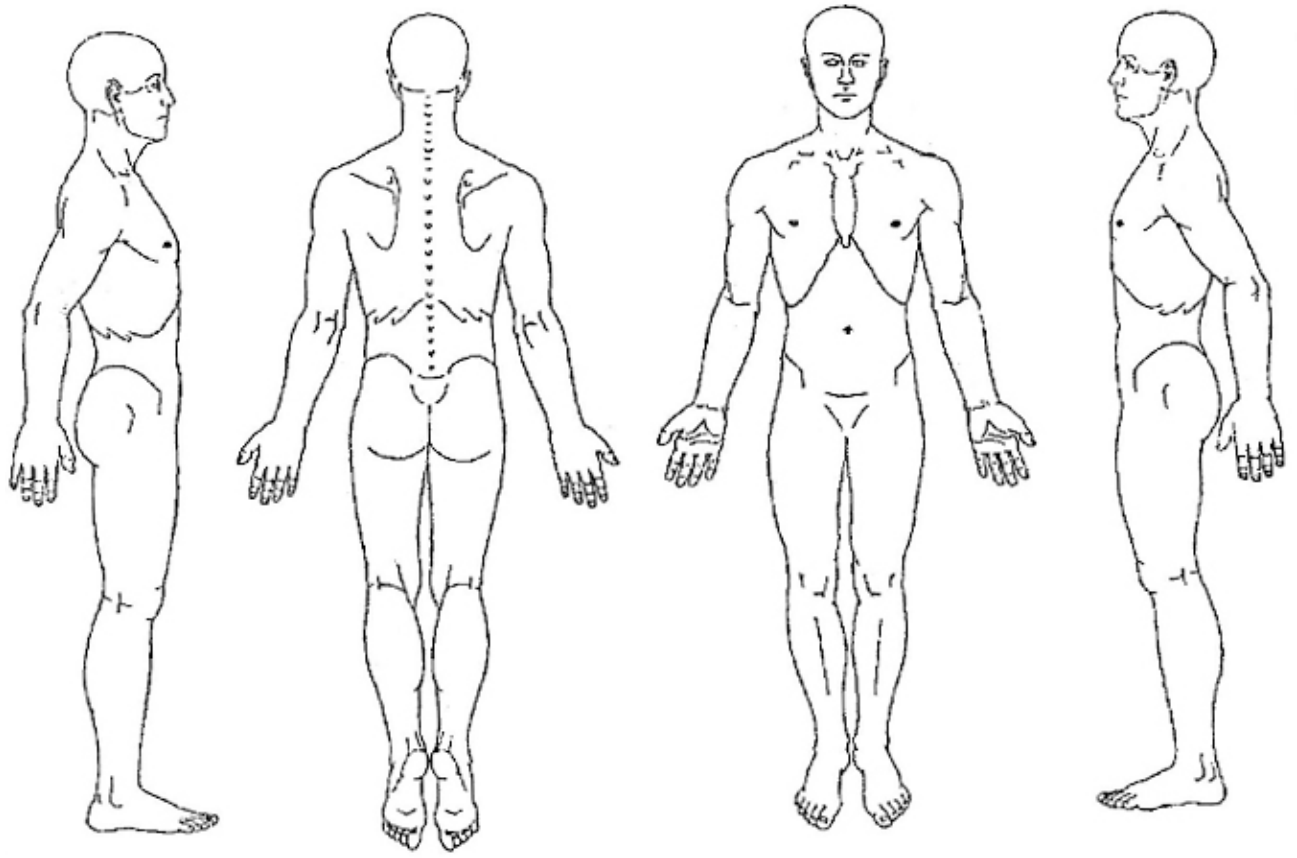
28. Do you have addiction(s) to refined sugars, artificial sugars, caffeine, nicotine, alcohol and or illicit drugs? **YES** **NO**

29. Do you have allergies, chronic pain (not due to trauma), frequent severe headaches, daily heartburn and or frequent infections? **YES** **NO**

30. Do you have degenerative disease(s) of aging? **YES** **NO**

31. Are you willing to make the changes in your lifestyle necessary to change your current state of wellness or fitness? **YES** **NO**

32. Please indicate on the figure below any areas in which you are currently experiencing discomfort and/or pain.



## Waiver

In consideration of my receiving services from Move Biomechanics, I, on behalf of myself, my heirs, executors, administrators and assigns, release Move Biomechanics, its servants, agents, employees and contractors from demands, damages, actions arising out of or in consequence of any loss, injury or damage to my person or personal property incurred while receiving any services provided by Move Biomechanics. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to update the practitioner as to any changes in my medical profile and understand that there shall be no liability on the practitioners part should I forget to do so. **I, the undersigned understand and acknowledge a 24 hour cancellation policy and accept all forwarding charges.**

Name: _____

Signature: _____

Date: _____