Therapy Roots, LLC
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Name (First & Last): _____

DOB: _____ Phone number: _____

Gender, preferred pronouns: _____

Address: _____

_____

Health Care Provider + Clinic: _____

Allergies/Sensitivities: _____

Current Health Problems you are experiencing (Please rate on a scale of 0-none to 10-worst pain you have experienced): _____

_____

_____

Have you ever had this problem before? If yes, when? _____

_____

List activities/Hobbies that you enjoy and participate in regularly: _____

_____

Current Providers you are working with: _____

_____

Past Surgeries &/Or Hospitalizations: _____

_____

Goals for Treatment:
1.
2.
3.

What are your expectations for this treatment? _____

_____

Check any major symptoms your are currently experiencing:

- ☐ Chronic Pain
- ☐ Muscle Tension/Joint inflammation
- ☐ Headaches
- ☐ Respiratory issues
- ☐ Cardiovascular concerns
- ☐ Urinary issues/concerns
- ☐ Fatigue
- ☐ Digestive Issues
- ☐ Sleep Disturbances/Insomnia
- ☐ Anxiety/Depression
- ☐ Numbness/Tingling
- ☐ Swelling
- ☐ None
- ☐ Other: _____

_____

What type of birth did you experience? (indicate if known)

- ☐ Cesceran (C-Section)
- ☐ Vaginal
- ☐ Forceps
- ☐ Vacuum
- ☐ Other:

Relationship Status (please circle): Single.....Married.....Divorced.....Widowed.....
Separated.....Partnered

Are you currently under any medical restrictions? _____

_____

Please list any medications and supplements: _____

_____

_____

List any major illnesses or diagnoses (past & present): _____

_____

What is your current level of stress? None.....Low.....Mild.....Moderate.....Severe

What is your primary source of stress? _____

How do you cope with stress? _____

Are you currently Pregnant: YES NO N/A

Have you given birth before: YES NO N/A

Are you the parent of any children? If yes, please list their names and ages.

_____

_____

Family History (Please include close relatives such as parents, siblings, children and grandparents and note any significant illnesses, diagnosis or cause of death if relevant)

_____

_____

_____

Signature: _____ Date:_____