call us: 1-877-767-3338 www.kevinrootmedical.com
fax: 1-866-919-9268 hello@kevinrootmedical.com

We are happy you are here and look forward to serving you.
Please complete the first three pages in full to help us serve you better – Thank you!

PATIENT INFORMATION:

Name:.. Email:...

DOB ..../......../............. (MM DD YYYY) **Sex:** ☐ **M** ☐ **F** Marital Status: ....

Mobile Phone:... Home Phone:...

Street Address: ....

City: .... State:.............. Zip: .... Country: ....

Occupation: ....

Employer: ....

Referred to by: .... **Date:** ..../......../............. (MM DD YYYY)

PATIENT HISTORY

1) What are your goals?

☐ Enhance performance
☐ Treat pain / pathology
☐ Prevent pathology
☐ All of the above
☐ None of the above. My goal is to: ....
....

2) Do you want to rely only on orthotics/braces for treatment alone OR would you like to mechanically change your body over time using biomechanical mindfulness along with orthotics/braces?

....
....

3) Do you enjoy excercise and how much do you move your body throughout the day?

....
....

4) As a teenager, in which activities did you participate, and at what level?

....
....

5) What activities do you participate in now?

....
....

PATIENT MEDICAL INFORMATION (USE BACK OF PAGE IF MORE ROOM NEEDED)

Shoe size: .... Weight: .... Height: ....

Allergies: ....

Medications: ....

Surgeries: ....

Orthopedic pain where and how long? ....

....

What previous treatment have you had? ....

....

Indicate which of the following you have had or have at present:

- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Murmur
- Hepatitis A ☐ / B ☐
- ☐ Varicose Veins
- ☐ Leg Aching
- ☐ Heaviness in Legs
- ☐ High Blood Pressure
- ☐ H.I.V. Positive
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Motion Sickness
- ☐ Neurological Disorder
- ☐ Psychiatric Care
- ☐ Psychological Care
- ☐ Stomach Problems
- ☐ Acid Reflux/Heartburn
- ☐ Ulcers (Diabetic)
- ☐ Leg Swelling
- ☐ Leg Cramps
- ☐ Restless Legs

Other History you feel is important for us to know: ....

....

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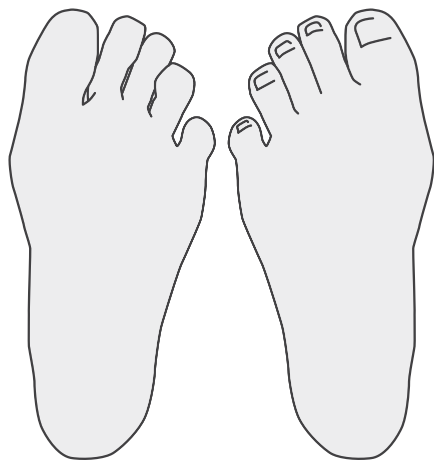
PAIN DESCRIPTION

Where is your pain right now?

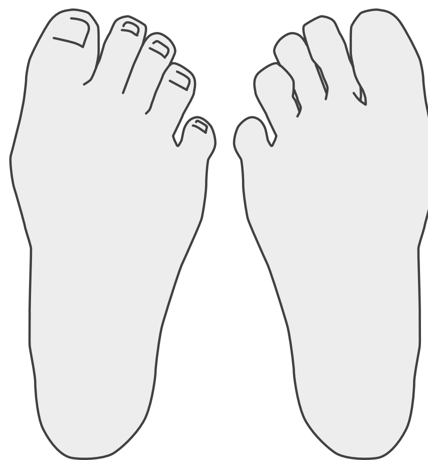
INSTRUCTIONS: Mark the areas on the foot and/or ankle where you have pain.
Please indicate which sensations you feel by referring to the key below.

KEY

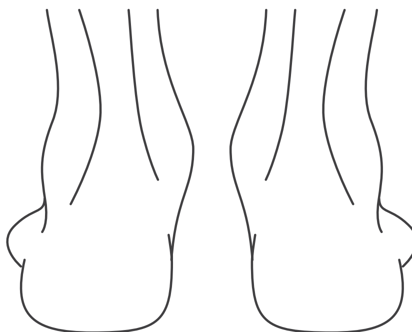
^^^ Ache	000 Numbness	■■■ Pins & Needles	XXX Burning	/////// Radiating Pain



LEFT FOOT



RIGHT FOOT



How bad is your pain right now? (indicate on the line)

0 • • • • • 1 • • • • • 2 • • • • • 3 • • • • • 4 • • • • • 5 • • • • • 6 • • • • • 7 • • • • • 8 • • • • • 9 • • • • • 10

No Pain **Intermediate Pain** **Worst Pain**