PERSONAL INFORMATION

Name: _____
Address: _____
Phone (1):_____ Phone (2):_____
E-mail: _____ Birthday: _____ Age:_____

EMERGENCY CONTACT

Name: _____
Phone:_____ Relationship: _____

MEDICAL INFORMATION

Are you seeing any medical practitioners such as MD, Osteopath, Chiropractor, Psychiatrist or Physical Therapist?

Medical Practitioner:_____ Office Phone:_____
Medical Practitioner:_____ Office Phone:_____
Medical Practitioner:_____ Office Phone:_____
Medical Practitioner:_____ Office Phone:_____

Are you currently taking any medications?

Medication:_____Purpose:_____
Medication:_____Purpose:_____
Medication:_____Purpose:_____

Have you ever had an X-Ray, MRI or CAT scan?

Diagnostic Test:_____ Date:_____
Diagnostic Test:_____ Date:_____
Diagnostic Test:_____ Date:_____

Have you ever had surgery?

Surgery:_____Date:_____
Surgery:_____Date:_____
Surgery:_____Date:_____

Have you ever had cosmetic surgery? (Facelift, breast augmentation, tummy tuck, liposuction, implants, etc.)

Surgery:_____Date:_____
Surgery:_____Date:_____
Surgery:_____Date:_____

Have you ever broken any bones?
Bone break:_____ Date:_____
Bone break:_____ Date:_____

Have you ever been involved in a car accident, or had a head injury such as whiplash, concussion or brain injury?
Type of injury:_____ Date:_____
Type of injury:_____ Date:_____

Do you currently, or have you ever had artificial splints, orthotics, dental splints, or orthopedic braces?
_____
_____
_____

Do you have, or have you ever been diagnosed with an autoimmune disease or systemic disorder such as MS, Lupus, Fibromyalgia, Rheumatoid Arthritis, Chronic Fatigue, Epstein Barr, HIV/Aids, Candida, Cancer, Heart Disease, Diabetes, Lyme's disease or any other condition related to immune suppression or systemic inflammation?
Diagnosis:_____Date:_____Treatment:_____
Diagnosis:_____Date:_____Treatment:_____

Do you have a history of food allergies and environmental sensitivities?
_____
_____
_____

What do you do for a living?_____

How does your job stress your body?_____

Are you physically active? If so, what do you do for fitness and how often?
Activity:_____ Times per week:_____
Activity:_____ Times per week:_____
Activity:_____ Times per week:_____
Activity:_____ Times per week:_____
Do any exercises, activities or body positions cause you pain or anxiety?
_____
_____

What are your hobbies?
Activity:_____ Times per week:_____
Activity:_____ Times per week:_____
Activity:_____ Times per week:_____

What else do you do for self-care (magnets, stretching, ice, etc.)?
_____

How would you describe your general state of physical health and energy now?
_____

Are you seeing any other practitioner outside of the traditional field of medicine such as an Acupuncturist, Massage Therapist, Rolfer, personal trainer, etc.?
_____
_____

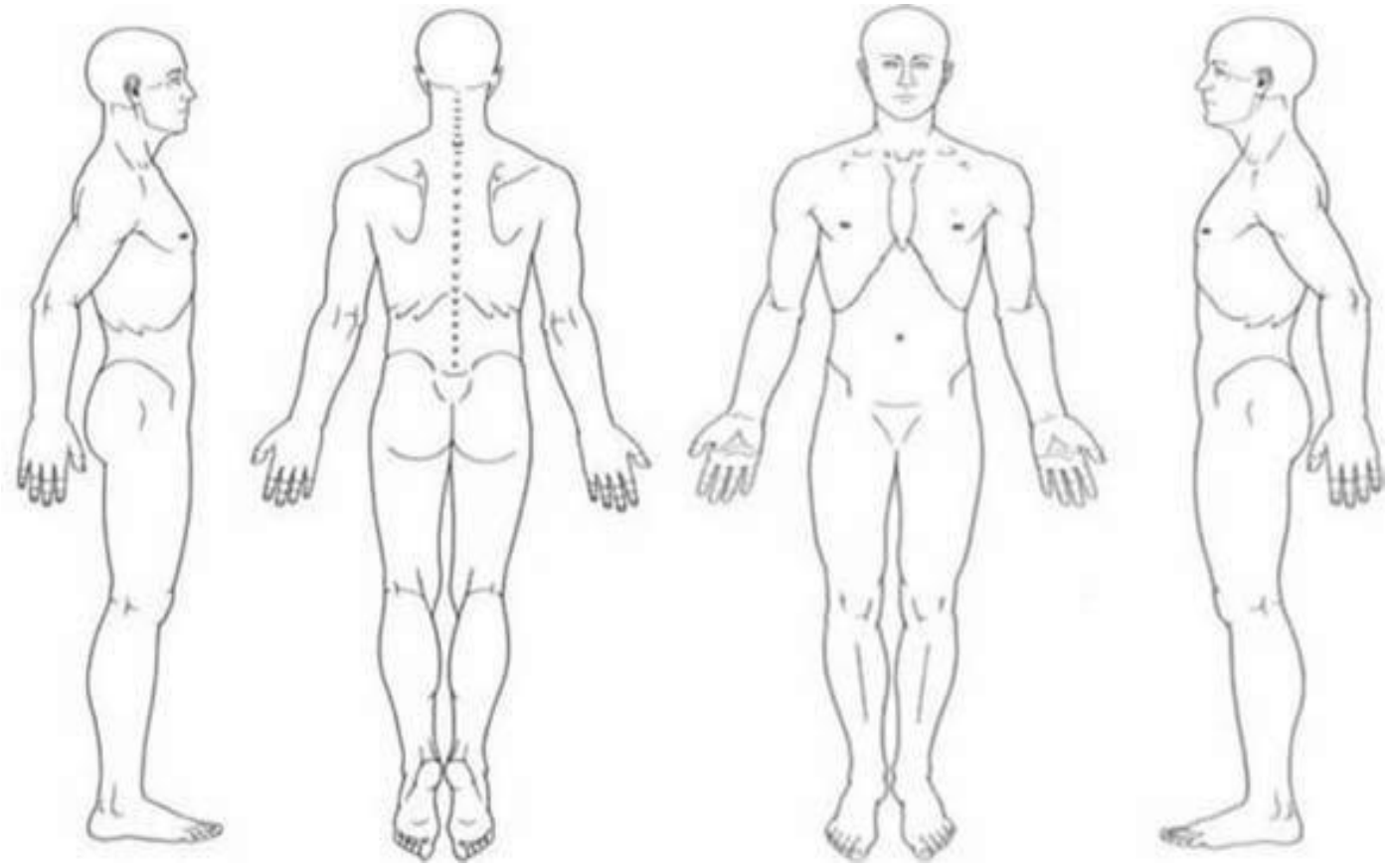
Have you ever had a negative reaction to any type of therapy (Physical Therapy, Chiropractic, Massage)?
_____

Are you taking any herbs or supplements?
Supplement:_____Purpose:_____
Supplement:_____Purpose:_____
Supplement:_____Purpose:_____

Have you ever seen an MAT Specialist before?
Name:_____ Date(s):_____
Name:_____ Date(s):_____

What results do you expect from your time and investment spent here?
_____
_____

How much time are you willing to commit to Muscle Activation Techniques?
_____
_____
_____
_____



Please Circle and describe areas of pain, discomfort, or past injuries: