

NAME: _____ AGE: _____

ADDRESS: _____

E-Mail: _____

PHONE NUMBER(s): _____

Emergency Contact Name/# _____

Referred By: _____

(MAT clients) What is your primary complaint: _____

What is your present pain level? 1=lowest 10=highest 1 2 3 4 5 6 7 8 9 10

List any surgeries have you had (Orthopedic, plastic, pregnancy, anything that cut skin)

0-19 yrs old: _____

20-29 yrs old: _____

30-39 yrs old: _____

40-49 yrs old: _____

50-59 yrs old: _____

60+ yrs old: _____

Please list all medications you are currently taking and for what reason: _____

Please list any diagnosed diseases, (autoimmune, systemic, cancer, etc.): _____

In the last year and currently, have you had any increases in stress in any of these areas?
Give explanation only if you feel comfortable. It is important to realize emotional stress can play a major role in muscle inhibition and therefore can relate directly too many of the pains we feel in the body.

Home: _____

Relationship(s): _____

Financial: _____

Health: _____

Work: _____

Please list any and all injuries you have had (diagnosed, accidents, falls, etc.)

0-19 yrs old: _____

20-29 yrs old: _____

30-39 yrs old: _____

40-49 yrs old: _____

50-59 yrs old: _____

60+ yrs old: _____

If you are a woman, how many children have you given birth to? _____

How many hours of sleep do you get? _____

How well do you sleep? (circle) Poor Average Great

How many hours of exercise do you perform in a week? (Circle)

0-2 2-4 4-6 6-8 8+

Are you currently training for an event? _____

Do you have a history of pain with exercise? Y N Pain that caused you to stop? Y N

If yes, please explain: _____

Please list all doctors you are **currently** under care with (phone number if you have it readily available), please also list the type of doctor (ex. Orthopedic, Chiropractor, etc)

Doctor: _____

Phone Number: _____

Doctor: _____

Phone Number: _____

Doctor: _____

Phone Number: _____

Doctor: _____

Phone Number: _____

Is there anything else you would like to share that may help me to better help you?

This Questionnaire is not intended for use as a diagnostic tool. We recommend all clients obtain a physical examination prior to beginning any exercise program or Muscle Activation Technique (MAT) sessions.

The client understands that any exercise activity in which he/she engages is done at his/her own risk. It is expressly understood that Activation Fitness, Inc. will not be liable for injuries or damages to client including without limitation, those injuries or damages resulting from acts of activity or passive negligence on the part of Activation Fitness, Inc. its successors and assigns, as well as its owners, officers, employees and agents, from all such claims, injuries or damages.

MAT is a bodywork technique using a systematic approach to identifying and treating muscular imbalances that relate to injury.

MAT addresses the component of muscle inhibition as a cause for limitations in joint range of motion. When muscles are inhibited, and/or have lost proprioceptive input, then the joint it supports becomes unstable. This instability must be identified and addressed. The MAT techniques are designed to identify and correct the positions of instability. When performed in this manner, the natural protective mechanisms are diminished and normal joint motion occurs. The end result is that we are not only increasing joint motion, but we are also making sure that there is increased stability through that range of motion (Mobility and Stability). The client understands when MAT is utilized; they are not receiving physical therapy or chiropractic work.

The undersigned certifies that he/she honestly and completely addressed each question in the questionnaire, has read the questionnaire and the above paragraphs in their entirety, and fully understands them. The client understands and agrees that during the visit he/she is not receiving physical therapy or chiropractic work.

Client Signature: _____ Date: _____