Client Information Form

Please complete the following form to help me get to know you and your health and movement history.,

Name _____ Date _____ Date of Birth _____
Address _____
City/State/Zip Code _____
Email _____ Cell Phone _____

Emergency Contact _____ Phone _____

** Would you like to be added to the Monthly Newsletter email list (1 email/month)? Yes ___ No ___

Why are you seeking MAT? _____

Describe any current issues, areas of pain or discomfort: _____
_____

Are you currently seeing or working with any other healthcare, movement, or wellness practitioners for current issues? (Examples: MD, osteopath, chiropractor, PT, acupuncturist, massage therapist, Rolfer, personal trainer, etc.)

Practitioner _____ Frequency _____ Helpful? Yes ____ No ___
Practitioner _____Frequency _____ Helpful? Yes ____ No ___
Practitioner _____Frequency _____ Helpful? Yes ____ No ___
Practitioner _____Frequency _____ Helpful? Yes ____ No ___

Is there anything you've found particularly helpful or unhelpful? _____

Have you ever had a negative reaction to any type of therapy? (PT, chiropractic, massage, etc)? If yes, explain:
_____

What, in particular, makes your pain or current issue worse? _____

What, if anything, makes it feel better? _____

Can you get comfortable at night? Yes ___ No ___

How do you feel upon rising? Stiff ___ Sore ___ Fine ___

Once you start moving through the day? Better ___ Worse ___ About the same ___

At the end of the day? Better ___ Worse ___ About the same ___

How is your current issue affecting the following activities?
1- NOT limited 2- some difficulty 3- significant difficulty 4- CANNOT do at all

Sleeping ____ Dressing ____ Sitting ____ Standing ____ Walking ____
Housework ____ Stairs ____ Sporting Activities ____

Other activity that's currently difficult or limited: _____

Are you currently taking any medications? If so, what are they and what are they for?
Medication _____ Purpose _____
Medication _____ Purpose _____
Medication _____ Purpose _____
Medication _____ Purpose _____

Have you had an X-ray, MRI or CT scan for the current issue?
Diagnostic Test _____ Date _____ Diagnosis _____
Diagnostic Test _____ Date _____ Diagnosis _____
Diagnostic Test _____ Date _____ Diagnosis _____

Have you ever had surgery, including cosmetic surgery?
Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____

If applicable: # of children _____ Delivery(vaginal/C-section) _____ Epidural? Yes ____No ____

Have you ever broken any bones?
Bone break _____ Date _____
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 _____
Type of injury _____ Date _____

Have you had any other significant injuries we haven't covered? If yes, explain.
_____
_____

Do you currently use, or have you ever used, orthotics, shoe inserts, splints, dental splints, or orthopedic braces? If yes, what and for how long? _____

Do you have any current or past medical conditions or diagnoses that you feel are important for me to know about? (Examples may include MS, rheumatoid arthritis, fibromyalgia, diabetes, cancer, etc.)
Yes ____No ____

Diagnosis _____ Date_____Treatment_____
Diagnosis _____ Date_____ Treatment_____

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

_____

_____

What do you do for a living? _____

On a scale of 1-10, list the level of stress you experience:

_____ Work
_____ Financial
_____ Relationships
_____ Home
_____ Health

Are you physically active? If so, what do you do for fitness and how often do you do it?

Activity _____ Number of times/wk _____
Activity _____ Number of times/wk _____
Activity _____ Number of times/wk _____
Activity _____ Number of times/wk _____

What are your hobbies?

Activity _____ Number of times/wk _____
Activity _____ Number of times/wk _____
Activity _____ Number of times/wk _____

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

_____

_____

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

_____

_____

Are you taking any herbs or supplements? If so, what are they and what are they for?

Supplement _____ Purpose _____
Supplement _____ Purpose _____
Supplement _____ Purpose _____

Approximately how much water do you drink daily?

_____ (8 oz glasses)

Approximately how much caffeine do you consume daily (tea, soda, coffee, energy drinks, etc)?

_____ (cups/cans)