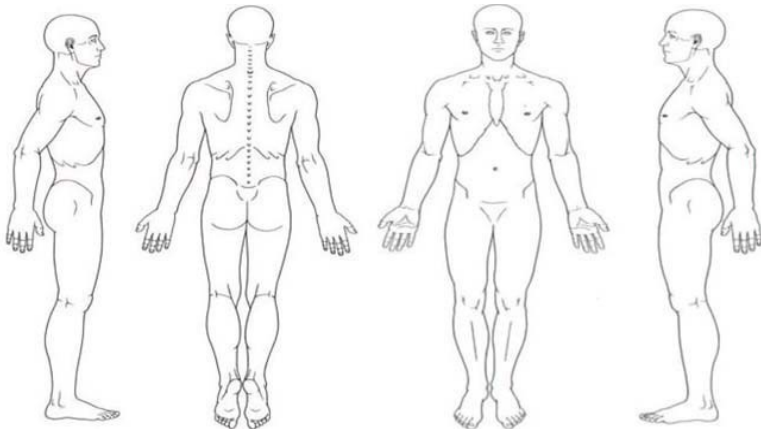
Holly Orvis, MATs, CMT Client Health Questionnaire

Name_____ **Date of Birth** _____

Address_____

Email _____ **Phone #** _____

1. Where do you currently feel pain, discomfort, weakness or tightness? Please mark on diagram. Please rate each site from 1-3.



2. What makes it worse? Ex: certain movements, exercises, sitting, bending, twisting, golf swing, ect. Please be specific.

_____

_____

_____

3. What makes it better?

_____

_____

_____

4. What have you tried so far to solve your problem/s?

Physical Therapy___ Massage___ Stretching___ Chiropractic___

Medication ___ Other/s _____

5. Have you had an MRI or an X-ray on the affected area/s?

   Yes___ No___ **If yes, please bring the report of findings and the films to your evaluation. If you do not have them, please contact your Doctor and request them.**

6. How does the problem/s affect your life?

   ___Hurts Work Performance or Productivity
   ___Interrupts Sleep
   ___Restricts Household Duties and/or Daily Activities
   ___Hinders Your Performance in Sports, Exercise or Other Social Activities
   ___Causes moodiness, irritability, depression, hopelessness, etc.

7. How important is it to you to finally solve your problem/s?

   ___It is one of my top priorities
   ___It is very important to me
   ___It is somewhat important to me

8. Please describe any and all injuries, pains and surgeries you have ever had no matter how minor or long ago. Please include dates. Use the back of page if necessary.

   Head/Neck_____

   _____

   Shoulder/Elbow/Hand/Wrist_____

   _____

   Mid/Low Back_____

   _____

   Hips/SI Joint/Pelvis _____

   _____

   Abdomen (including surgeries) _____

   _____

   Knees _____

   _____

   Feet/Ankles/Toes _____

   _____

   Muscular strains/Tears_____

   _____

9. Are you currently being treated for any of these prior ailments? (medication/therapy, etc) If so, which one/s and with what?

_____

_____

_____

10. Please describe in full detail what types of physical activity you participate in, how often you do it and how long you have been doing it. (i.e. exercise, sports, walking, biking, swimming, housework, gardening, etc)

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11. Health History:

YES	NO	
____	____	History of ANY Cardiovascular (heart) problems
____	____	History of ANY Pulmonary (lung) problems
____	____	Diabetes or any other metabolic disease
____	____	Recent pain and/or swelling in your legs
____	____	Any Allergies or skin sensitivities (especially to oils/creams)
____	____	Pregnant or Postpartum
____	____	Currently taking any prescribed medication (please list if YES)

_____

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Recovery/Healing Rate Analysis

This section is designed to determine how fast your body is likely to recover and heal from physical ailments, as well as determine how quickly it is likely to improve in its performance. Each of these factors plays a very important role in those processes. Please answer each question to the best of your ability.

1. On average, how many cups of pure water do you drink each day? Does this vary, if so when and how?

_____

_____

_____

2. On average, how many hours of continuous sleep do you get each night? Do you wake up feeling rested? Does this vary? If so, when and how?

_____

_____

_____

3. How would you rate the stress you have each day 1-10? (1= no stress ever 10=highly stressed often) What are the common stressors? Does this vary? If so, when and how?

_____

_____

_____

4. How often do you consume the following foods and beverages? Include frequency and quantity and type/s.

   Sweet foods/drinks

   _____

   Fried foods

   _____

Dairy

_____

Meat

_____

Alcohol

_____

Wheat products

_____

5. Do you have any allergies? If so, to what?

_____

_____

_____

6. On average how often do you get sick each year? How long does it usually take you to recover? Does this vary? If so, when?

_____

_____

_____

7. Please list any and all medications you are taking, what they are for and how long you have been taking them. Please include over the counter drugs and nutritional supplements as well. Use the back of the page if necessary.

_____

_____

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Physical Health and Wellness Goals

1. What are your top 3 short term (to achieve within a year) goals for your physical health and wellness?

    1. _____
    2. _____
    3. _____

2. What are your top 3 long term (to achieve within 5-10 years) goals for your physical health and wellness?

    1. _____
    2. _____
    3. _____

3. How long do you think it will take to reach your short term goals? How about your long term goals?

_____

_____

_____

_____

4. Were you referred to MAT by someone? If so, what were you told about how it could help you solve your problem/s and/or achieve your physical goals?

_____

_____

_____

_____

Cancellation Policy:

I am making a commitment to guarantee your appointment time and refusing all other requests once you have made the appointment. A 24-hour cancellation notice is required for all scheduled appointments including gift certificate sessions. Missed or no-show appointments will result in you being charged the full amount of the session booked. Depending on our booking schedule, late appointments may not receive the full session time allotted for the treatment service booked; however, full payment is required. Emergency cancellations are determined by the Practitioner's discretion. Your business is valued and your cooperation is appreciated.
Please initial:_____

Informed Consent for Muscle Activation Techniques™ Services:

Muscle Activation Techniques™ is a bodywork technique using a systematic approach to identifying and treating muscular imbalances that relate to injury. The focus of the evaluation procedure is based upon the understanding that the body will protect itself when it recognizes instability. Therefore, muscles tighten up as a protective measure when instability is recognized.

Muscle Activation Techniques™ addresses the component of muscle weakness as a cause for limitations in joint range of motion. When muscles are weak, and/or have lost proprioceptive input, then the joint that 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 & Stability).

The undersigned understands and agrees that during the visit he/she is not receiving physical therapy or chiropractic work. It is understood that Muscle Activation Techniques™ is the only technique used in this session.

_____ **Signature** _____**Date**

Informed Consent for Massage Therapy Services:

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly, and will keep the practitioner updated to any changes in my medical profile. I hereby release the practitioner and the facility from any and all liability for illness, injury or death sustained during, or as a result of, any activity engaged in while under the care of Holly Orvis and on the premises of Purvis Properties, LLC.

_____ **Signature** _____**Date**