Muscle Activation Techniques (MAT) Questionnaire

Name:_____ Date of Initial Visit:_____

Address:_____
_____

City, State,
Zip:_____
_____

Phone: (Day) _____ (Evening) _____(Cell)_____
(Email)_____

Date of Birth: _____

Occupation: _____
Employer:_____

Referred By: _____ Physician:
_____

1) Have you ever had MAT before? Yes_____ No_____

2) Do you have difficulty lying on your front, back, or side? Yes_____ No_____

3) Do you experience stress in your work, family, or other aspects of your life? Yes____ No____

-How would you describe your stress level? Low___ Medium ___ High ____ Very High ____

-If high, how do you think your stress has affected your health? Muscle Tension ( ),

-Anxiety ( ), Insomnia ( ), Irritability ( ), Other

_____

6) For women: Are you pregnant? Yes ___ No ___ If yes, how many months? _____

7) What is your major complaint, if any that you want to improve?

_____

_____
_____

_____

8) When did you first notice this complaint?

_____

9) What event(s) brought it on?

_____

_____
_____

10) What activities aggravate the condition?

_____

11) What have you done to get relief?

_____

12) What are your expectations for this visit?

_____

13) Are you currently under medical supervision? Yes ____ No ____

14) Are you currently taking any medications? Yes ___ No ___ If yes, please list:

_____

_____
_____

_____

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

___Headaches
___Pregnancy:
___Joint stiffness/swelling
___Current ___Previous
___Spasms/cramps
___Broken/fractured bones
___Menopause
___Strains and sprains
___Back, hip pain
___Endometriosis
___Shoulder, neck, arm, hand
___Other:_____

Reproductive System

___PMS
___Pelvic inflammatory disease

Pain

___Leg, foot pain
___Chest, ribs, abdominal pain
___Cancer
___Problems walking
___current___remission
___Jaw pain/TMJ
___Diabetes
___Tendonitis
___Bursitis
___Alcohol Use_____
___Arthritis
___Nicotine Use_____
___Osteoporosis
___Caffeine Use_____
___Scoliosis
___Hearing Impairment
___Bone or Joint Disease
___Visual Impairment
___Fibromyalgia
___Infectious Disease_____
___Other

___Surgeries:_____

Skin

___Rashes
___Allergies
___Athlete's Foot
___Warts
___Moles
___Acne
___Other:_____

Digestive

___Nervous stomach
___Indigestion
___Constipation
___ Diarrhea
___ Diverticulitis
___ Irritable Bowel Syndrome
___ Crohn's Disease
___ Adaptive aids
___Other_____

Other

___Drug Use_____

Circulatory and Respiratory

___Dizziness/lightheadedness
___Shortness of breath
___Fainting
___Cold feet or hands
___Lymph edema
___Swollen ankles
___Pressure sores
___Varicose veins
___Blood clots
___Stroke
___Heart condition
___Sinus problems
___Asthma
___High Blood Pressure
___Spinal cord injury
___High Blood Pressure
___Low Blood Pressure
___Other:_____
___Other_____

Nervous System

___Numbness/ tingling
___Twitching of face
___Fatigue
___Chronic pain
___Sleep Disorders
___Ulcers
___Shingles
___Chronic Fatigue Syndrome
___Cerebral Palsy
___Epilepsy
___Multiple Sclerosis
___Muscular Dystrophy
___Parkinson's Disease
___Paralysis

Please list any additional comments regarding your health and well being:
_____

_____
_____

All of the above information is correct to the best of my knowledge. I realize that this session is for treating muscular imbalances and is not intended to diagnose any condition that I may have. I will not hold the Muscle Activation Techniques Specialist liable for any exacerbated condition that was not disclosed in the above questionnaire.

Signature:_____ Date:_____

Print Name:_____