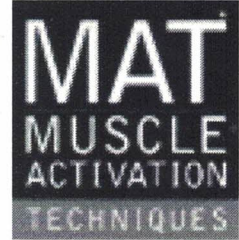


Health Information

Date: _____



Client General Information

Name: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Preferred form of communication (circle one): email call text May we leave voicemail? _____

Emergency contact: _____ Phone: _____

Physician/Health-care provider name: _____ Phone: _____

Your Occupation: _____

How do you spend most of your work day? Sitting Standing Light Labor Heavy Labor

Exercise habits? None Moderate Daily

Are you pregnant? Yes No Do you have a pacemaker? Yes No

Multiple Sclerosis? Yes No Neuropathy? Yes No

Parkinson's disease? Yes No Arthritis? Yes No

Recent fall? Yes No Recent surgery? Yes No

Recent broken bone? Yes No

Please use this space to explain any of the "yes" answers from above or to add anything that was not mentioned.

Please fill out the backside

Do you have any joint replacements? If so, which one(s) are replaced?

Please list any injuries/surgeries/medications that may influence today's treatment:

How did you hear about MAT/our practice? _____

If you were referred, who referred you? _____

Reason for seeking Muscle Activation Technique (MAT):

Have you tried any other modalities to treat the issue that you are here to get treated for?
Please explain. Include the results you have had with each treatment.

Is there anything you do to try to relieve the symptoms?

Do you have any special needs that your practitioner needs to prepare for? (ex. Cannot lay on stomach)

Do you have any questions/concerns?

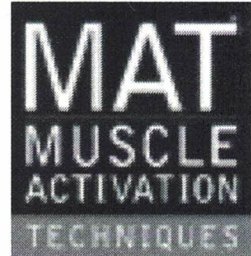
Name: _____

Date: _____

Terms of Acceptance

Informed Consent:

Muscle Activation Techniques (MAT) is a bodywork technique using systematic approach to identify and treat muscular imbalances that relate to injury and pain. This is a hands-on biomechanical technique that requires manual palpation of the origin and insertion of muscles. This may involve a mild degree of discomfort at these sites. In addition, some isometric exercises might be introduced.



The undersigned understands and agrees that during the visit he/she is not receiving physical therapy, chiropractic treatment, or medical treatment. It is understood that MAT is the only technique used in this session. MAT cannot be used to diagnose, treat or cure any medical condition. Please consult your physician before beginning any workout or treatment program. Any questions about the procedures used during MAT sessions are encouraged. If you have any concerns or questions, please ask for further explanations.

A patient, in coming to the MAT practitioner, gives the practitioner permission and authority to care for the patient in accordance with the MAT treatment plan. This treatment plan is usually beneficial and seldom causes any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The practitioner, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the MAT practitioner. The MAT practitioner provides a specialized, non-duplicating health care service. Your MAT practitioner is certified in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a MAT practitioner at Muscle Activation, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding MAT treatment, will be explained to me upon request.

Signature: _____

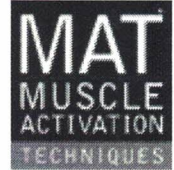
Date: _____

Consent to Evaluate and Treat a Minor

I, _____, being the parent or legal guardian of _____, Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive MAT treatment. For future visits I authorize my minor child to receive treatment without my presence if needed.

Signature: _____ Relation to child: _____ Date: _____

Howell Chiropractic, Inc.
1311 E. Stroop Rd., Kettering, OH 45429
937-558-2824 (p) 937-558-5679 (f)
Julie Smith - MAT Specialist, LB



MAT Office Policies

Cancellation

A 24-hour notice is required for cancellation of an appointment, or you will be charged in full for the appointment. Payment is due before your next appointment. Once there is a record of 3 missed appointments without any communication, services will likely no longer be offered to this individual.

Tardiness

Appointment times are scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time for your appointment.

Sickness

MAT is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24 hour notice period, the cancellation fee may be waived.

Financial Responsibility

Appointments must be paid in full by or on day of the appointment. The previous appointment must be paid for before scheduling the next one. Ask your practitioner about which payment options are accepted. Any returned checks are subject to a fee.

Your signature below signifies acceptance of these policies. Let us know if you have any questions or concerns.

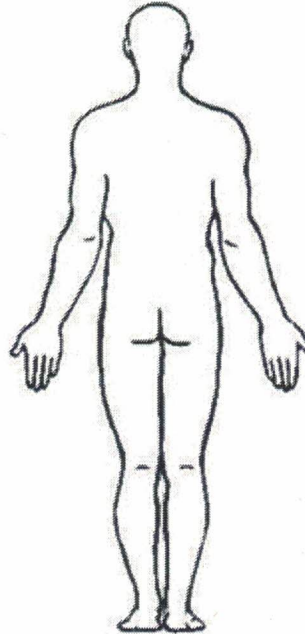
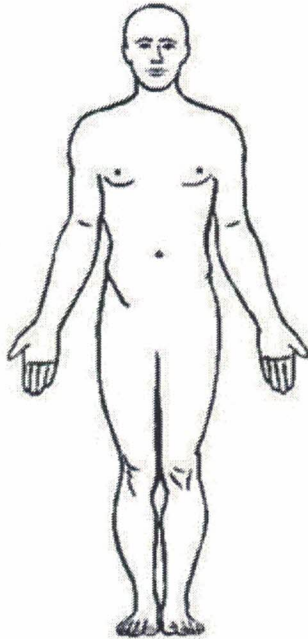
Signature: _____

Date: _____

What is bothering you today?



Name: _____ Date: _____



Circle all that apply:

Pain Stiffness Inflammation Tension Tightness Muscle
Spasms Numbness Tingling Swelling Other: _____

Please rank your level of [symptom you circled]: 1 2 3 4 5 6 7 8 9 10

Has anything changed since last session (good or bad)? If applicable, please explain.

During what activities do you notice the issue? (ex. Walking up stairs, lifting my arm) Please write multiple examples if possible.

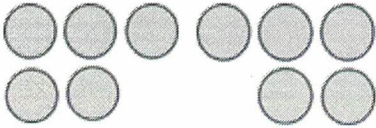
For practitioner use only

Int rot



Limited CAMs:

Ext rot



L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

L R _____

Notes: