Dave Reed's Kinetic Symmetry, Inc.

Client Intake Form

Client information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name:	Date of Birth:
Street Address:	
City:	State: Zip:
Email Address:	
Cell Phone: ( )	Home Phone: ( )
Work Phone: ( )	**PLEASE circle the best way to contact you.**
How did you hear about MAT?	

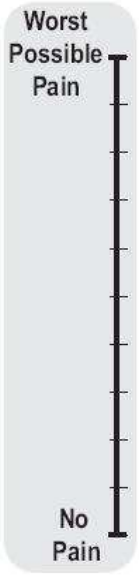
Current Complaint/Condition

What would you like to accomplish through MAT treatment? _____

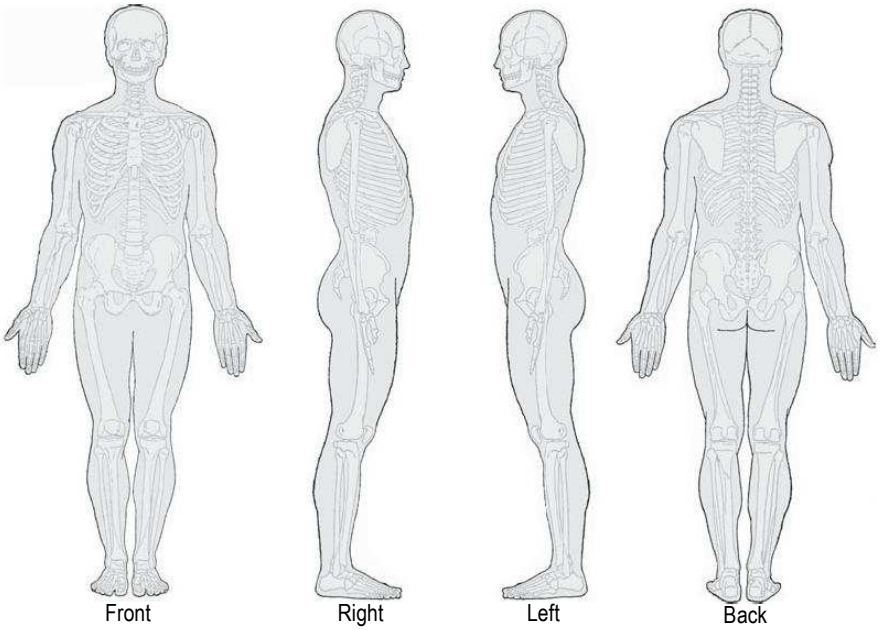
Give a brief detailed description of the problem you are currently experiencing: _____

When did you first notice the complaint/condition? What seemed to be the initial cause? _____

Please place a mark at the level of your pain on the scale below:



Please mark your area(s) of pain/complaint on the figure below:



What physical activities and/or positions aggravate your condition? (e.g., kneeling down, reaching overhead, golf, running)

What physical activities and/or positions provide relief? (e.g., sleeping position, sitting down,)

What methods do you currently use to manage your complaint? (e.g., ice packs, stretching, massage, chiropractic etc…)

Over the course of an average day when is the pain level the greatest? _____ The least? _____

Have you seen or currently seeing any other health care practitioner for your current physical pain/complaint?

Name	Care Provided

Medical/Health History

Please list ***every*** significant physical pain you have ever experienced, including non-medically treated injuries.

Body Part	**Injury/Trauma/Surgery (please include age and/or date of occurrence)**
Head / Jaw (e.g., clicking jaw, concussion)	
Cervical / Neck (e.g., whiplash)	
Thoracic / Mid-back	
Lumbar / Low-back	
Abdominal / Ribs (e.g., Hernia)	
Pelvis / Hips / Femurs / Thighs	
Shoulders / Rotator Cuffs	
Elbows (e.g.,tennis or golfer's elbow)	
Wrists / Hands (e.g., carpal tunnel syndrome)	
Knees / Patellae (e.g.,ACL, knee replacement)	
Ankles / Feet (e.g., plantar fasciitis)	

*Please provide any radiological reports you may have from X-Rays or MRIs.

Have you ***ever*** been involved in a Motor Vehicle Accident? ☐ No ☐ Yes If yes, when and did you have any subsequent pain?

Have you had any cosmetic surgery? ☐ No ☐ Yes If yes, please describe: _____

Have you had any dental work? (e.g., braces, night guard, appliances) ☐ No ☐ Yes If yes, please describe:

Do you currently use orthotics or any orthopedic/corrective shoes? (e.g., heal lift, anti-pronating shoes) ☐ No ☐ Yes

Are you currently pregnant? ☐ No ☐ Yes Due Date: _____ Have you given birth to any children? ☐ No ☐ Yes

If so, how many and were any via C-Section? _____

Check if you currently have or have experienced any of the following conditions:

□ Numbness in Extremities	□ Rheumatoid Arthritis	□ Chronic Fatigue Syndrome	□ High Cholesterol
□ Diabetes Type I	□ Psoriatic Arthritis	□ Crohn's Disease	□ Hypertension
□ Diabetes Type II	□ Fibromyalgia	□ Eating Disorder	□ Asthma
□ Neuropathy	□ Lupus	□ Hemophilia	□ Stroke

Elaborate if needed: _____

Please list any prescription and/or over-the-counter medications you are currently taking: (use reverse side of page if needed)

Name of Medication	Dosage	Why and how long have you been taking this medication?

Please list any nutritional/dietary supplements you are currently taking: (Use reverse side of page if needed)

Name of Supplement	Dosage	Why and how long have you been taking this supplement?

Fitness, Wellness and Lifestyle

Please describe your current activity level:

- ☐ Sedentary (No exercise)
- ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
- ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

If you exercise regularly, describe the activities and frequency: _____

How long have you participated in regular exercise programs? _____

Are you currently using a personal trainer? ☐ No ☐ Yes If so, please include name and contact info.

Were you a high school or college athlete? ☐ No ☐ Yes If yes, please list sports and positions:

Do you have any specific fitness goals? ☐ No ☐ Yes If yes, please describe:

Are you currently following a special diet or eating program? ☐ No ☐ Yes If yes, please describe:

How many glasses of water do you drink on average per day? _____

Do you drink coffee? ☐ No ☐ Yes If yes, how much and how often? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how much and how often? _____

Do you have any food allergies/sensitivities? ☐ No ☐ Yes If yes, please describe:

Do you smoke? ☐ No ☐ Yes If yes, how much and how often? _____

What is your current occupation? _____

What percentage of the day are you standing? _____ Sitting? _____

Describe your daily stress level on a 1-10 scale with 10 being the greatest amount. _____

On average how many hours of sleep do you get per night? _____

Please include any additional comments or concerns you may have.

Dave Reed's Kinetic Symmetry, Inc.

MAT Informed Consent, Waiver, Release of Liability and Consent to Medical Attention Form

INFORMED CONSENT

Muscle Activation Techniques (MAT) is a bodywork technique using a systematic approach to identify and treat muscular imbalances that relate to injury and pain. The focus of the evaluation procedure is based upon the understanding that the body will protect itself when it recognizes instability. Therefore, muscles will tighten up as a protective measure when instability is recognized. MAT addresses the component of muscle weakness as a cause for limitations in joint range of motion. When a muscle is inhibited and/or has lost proprioceptive input, it does not contract efficiently, and the joint that it supports becomes unstable. MAT is designed to identify and correct the positions of instability. When MAT is performed, the natural protective mechanisms are diminished and normal joint motion occurs. The goal is to not only increase joint motion, but to also increase stability through that range of motion (Mobility and Stability).

MAT 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.

I hereby consent to voluntarily engage in MAT sessions. My permission to perform this technique is given voluntarily. I understand that I am free to stop the session at any time if I so desire**.** _____ **(Initial)**

I hereby acknowledge that MAT is a scheduled event and hereby agree to pay for services at the time of treatment. *All cancellations must be made 24 hours prior to appointment to avoid charge for service***.** _____ **(Initial)**

Any questions about the procedures used during MAT sessions are encouraged. If you have any concerns or questions, please ask for further explanations.

WAIVER, RELEASE OF LIABILITY AND CONSENT TO MEDICAL ATTENTION

In Exchange for my being allowed to participate in Dave Reed's Kinetic *Symmetry, Inc.* (*"Kinetic Symmetry"*) programs and opportunities (the *"Activity"*), I, and if I am not yet 18 years old, my parent or legal guardian (individually and collectively referred to below in the first person singular) agree to be bound by each of the following:

1. Identification of Risks: I understand that participation in the *Activity* may involve risk of injury, disability and death.

2. Assumption of Risk: I am physically and psychologically ready to participate in the *Activity* and assume all risks connected with my participation in the *Activity*. I accept personal responsibility for any liability, injury, loss or damage in any way connected with my participation in the *Activity*.

4. Status of *Kinetic Symmetry:* I understand and represent that *Kinetic Symmetry* (including its affiliated organizations, directors, officers, sponsors, employees, agents, successors, and assigns) is not my physician and that the *Activity* does not constitute the provision of medical or health care services.

5. Waiver and Release: I release and discharge *Kinetic Symmetry*, and each of its affiliated organizations, directors, officers, sponsors, employees, agents, successors, and assigns from all claims for any liability, injury, loss, or damage in any way connected with my participation in the *Activity*, whether or not caused in whole or part by the negligence of any of the organizations or individuals mentioned above. I intend for this waiver and release to also apply to my relatives, personal representatives, heirs, beneficiaries, next of kin, and assigns who might pursue any legal action or claim for such liability, injury, loss or damage. I further intend that this waiver and release shall be effective indefinitely and unless and until I provide written notification to *Kinetic Symmetry* to the contrary. This waiver and release nullifies any prior waiver and release signed by me.

6. Consent to Medical Treatment: I agree that *Kinetic Symmetry* (including its affiliated organizations, directors, officers, sponsors, employees, agents, successors, and assigns) may, but has no duty to provide me, through medical personnel of their choice, customary medical or training assistance, transportation, and emergency medical services.

I have read this waiver, release and consent and understand that I have given up substantial rights by signing it. I am signing this waiver, release and consent voluntarily.

If the person participating in the Activity is not yet 18 years old: As a parent or legal guardian of the above named child, I verify that I fully agree to, understand, and accept all provisions of this waiver, release and consent.

Client Signature

Parent/Legal Guardian Signature

Printed Name Date

Printed Name Date

Specialist Signature Date