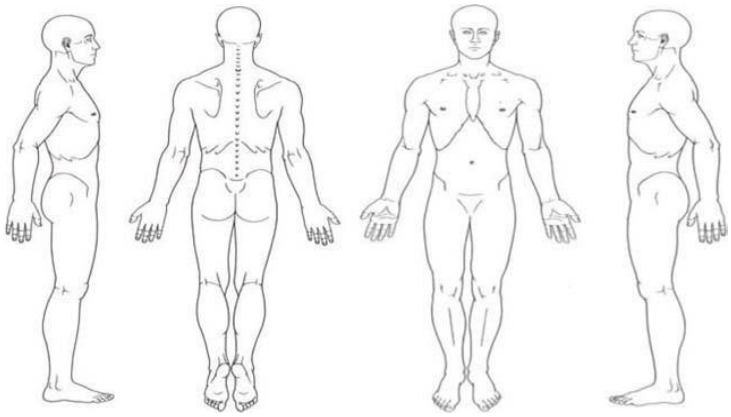
Client Health Questionnaire

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.



1- Rarely bothers me

2- Bothers me only after/during certain activities or movements

3- Always bothers me

2. What makes it worse? Ex- certain movements, exercises, sitting, bending, twisting, golf swing, etc. 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. Does the current problem/s cause you to be?

   ___Moody
   ___Irritable
   ___Depressed or Hopeless
   ___Restricted on Daily Activities

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

   ___Hurts Work Performance or Productivity
   ___Interrupts Sleep
   ___Restricts Household Duties
   ___Hinders Your Performance in Sports, Exercise or Other Social Activities

8. 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

9. ******PLEASE READ THIS CAREFULLY******

   On the following two pages are grids that need to be filled out in as much detail as possible. The vertical columns are separated by age and the horizontal rows are separated by body part. Please list every injury, trauma, surgery or pain you've had to each of these areas in the appropriate column. For instance, if you strained your lower back while lifting when you were 25 years old, write "strained lower back while lifting" in the 20-29 column. Please contact us at info@matrixofmotion.com if you have questions.

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	0-19 years old	20-29 years old	30-39 years old	40-49 years old	50-59 years old	60-69 years old	70+ years old
Head and Neck							
Shoulders, arms, elbows, wrists and hands							
Mid back and scapular regions							
Chest and abdomen (including surgeries)							
Lower back and pelvis							

	0-19 years old	20-29 years old	30-39 years old	40-49 years old	50-59 years old	60-69 years old	70+ years old
Hips and thighs							
Knees							
Feet and lower legs							

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

11. Who are your current medical/healthcare/fitness providers?

Name_____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Would you like any of these providers to be given evaluation or session summaries while we are working together? __ Yes __ No If so, which one/s?

_____

_____

12. 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.)

_____

_____

_____

_____

_____

_____

_____

_____

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. Do you have any diagnosed diseases? If so, Please list each one.

_____

_____

_____

_____

7. 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?

_____

_____

8. 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.

_____

_____

_____

_____

_____

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/or maintain over the next 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 Matrix of Motion Fitness Studios and/or Muscle Activation Techniques by someone? If so, what were you told about how we could help you solve your problem/s and/or achieve your physical goals?

_____

_____

_____

PAR-Q

Please read the questions carefully and answer each one honestly:

Check YES or NO

YES	NO	
□	□	Has your doctor ever said that you have a heart condition *and* that you should only do physical activity recommended by a doctor?
□	□	Do you feel pain in your chest when you do physical activity?
□	□	In the past month, have you had chest pain when you were not doing physical activity?
□	□	Do you lose your balance because of dizziness, or do you ever lose consciousness?
□	□	Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
□	□	Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
□	□	Do you know of any other reason why you should not do physical activity?

I hereby request and consent to the performance of Muscle Activation Techniques, physical activity and exercise while being supervised by a Registered Kinesiologist and/or Personal Trainer. I understand that the Kinesiologist and/or personal trainer may practice other health modalities, however I am not requesting those treatment services. I do not and will not hold the Kinesiologist and/or personal trainer liable for negligence and/or malpractice during the course of the exercise continuum program.

I affirm that my answers to each question listed are truthful and answered to the fullest extent and the best of my ability. I agree to be upfront and honest about my health situation in all aspects that are deemed relevant to the improvement of my current situation. **I understand that MAT and exercise is a**

non-medical process that is not intended to diagnose or treat pain or medical conditions. I also understand that MAT and exercise is not a "quick-fix" or a "miracle cure", but rather a way to gradually improve my body's function over time which will in turn make me stronger, more flexible and improve my ability to heal, resist injury, achieve peak performance and age better.

I understand that all fees for the services are to be paid at the time of the appointment. I also understand that Ontario Health Insurance Plan (OHIP) does not cover Kinesiology or Personal Training. I agree to respect my practitioner and their time by showing up for my scheduled appointments to the best of my ability. **I understand that I will be charged for any session that I do not show up for, or that I cancel within 24 hours of the agreed upon appointment time.**

I am at least sixteen years of age (or have parental consent) and I have read the above statement. I have had the opportunity to ask questions about the content, and by signing below, I agree to the performance of Muscle Activation Techniques, physical activity and exercise. I intend for this consent to cover the entire course of treatment for my present condition and for any future conditions.

_____ _____

Name (please print) Signature

_____

Date

In case of an emergency, please provide an emergency contact.

Name _____

Phone Number _____

Relation _____