EuKinetics

Muscle Activation Technique

CLIENT HISTORY:

NAME:
AGE:
ADDRESS:

PHONE:
WORK:
CELL:
HOME:
FAX:

DOB:
EMAIL:

BEST WAY TO CONTACT YOU:

EXPLAIN YOUR REASON(S) FOR COMING TO SEE ME FOR THERAPY:

HAVE YOU PREVIOUSLY HAD ANY OTHER TREATMENT(S) TO TAKE CARE OF YOUR PROBLEM?

HAVE YOU HAD ANY PREVIOUS INJURIES, FRACTURES, SPRAINS, STRAINS, OR SURGERIES (They do not have to pertain to your current problem):

CURRENT PAIN (be descriptive, anytime, anywhere, headaches, neck, shoulders, back, feet, etc) Please rate on a scale of 1-10, 10 being at its worst.

TODAY_____ BEST_____ WORST_____

ARE THERE POSITIONS OR ACTIVITIES THAT MAKE THE PAIN WORSE?
If so please describe:

SLEEP: How many hours, on average a night?
What time, on average do you go to sleep?
Do you have a hard time falling asleep?

If so, why do you think it is difficult to fall asleep and what have you tried to get to sleep?

Do you ever wake up during the evening at a consistent time? (For example, "I wake up at 3 am at least 2-3x per week, I am usually thirsty/hot/in pain?)

GO THROUGH A NORMAL DAY, FROM THE TIME YOU WAKE UNTIL YOU GO TO SLEEP:

POSITION DURING DAY (for example, seated at a computer all day):

HEALTH CONDITIONS OR CONCERNS (high blood pressure, MS, etc)

DO YOU WEAR ORTHODICS? YES/NO
IF YES, HOW LONG?

MEDICATIONS CURRENTLY ON AND FOR WHAT:

CURRENT SUPPLEMENTS:

KNOWN ALLERGIES (food, seasonal, animal, etc):

NAMES OF ANY OTHER HEALTH PROFESSIONALS YOU ARE CURRENTLY WORKING WITH: (massage, chiro, pt, etc.)

WOULD YOU LIKE ME TO CONTACT THEM FOR INFORMATION ON YOUR INJURY AND CURRENT REHAB? If so, please include phone number and fax.