Matrix Therapy, LLC
678-520-0986
carrie.matrixtherapy@gmail.com

Name: _____ Date of Birth:_____

Address:_____ Phone Number: _____

_____ email: _____

Referring physician: _____

Primary Physician: _____
Medical History:
List all current and previous orthopedic injuries: _____

_____

_____

_____

- ☐ heart disease
- ☐ high blood pressure
- ☐ malignancy
- ☐ auto immune disorder
  Please list:_____
- ☐ mental illness
  Please list: _____
- ☐ DVT
- ☐ Hemmorage
- ☐ Stomach ulcers
- ☐ Diabetes
- ☐ Fractures
  Please list: _____
- ☐ Stroke
- ☐ TBI
- ☐ Chronic Fatigue Disorder
- ☐ Cancer

Type:_____
Location:_____

- ☐ Cerebral palsy
- ☐ Parkinson's disease
- ☐ Multiple sclerosis
- ☐ Peripheral neuropathy
- ☐ Vascular disease
- ☐ Insomnia
- ☐ Depression
- ☐ Thyroid imbalances
- ☐ Metabolic disorders
- ☐ Hormonal irregularities
  Please list:_____
- ☐ Other:_____
  _____
  _____

Please list all previous injuries/accidents that have occurred: _____

_____

_____

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Reason for therapy/what do you hope to gain from therapy: _____

_____

_____

Please list all surgeries: _____

_____

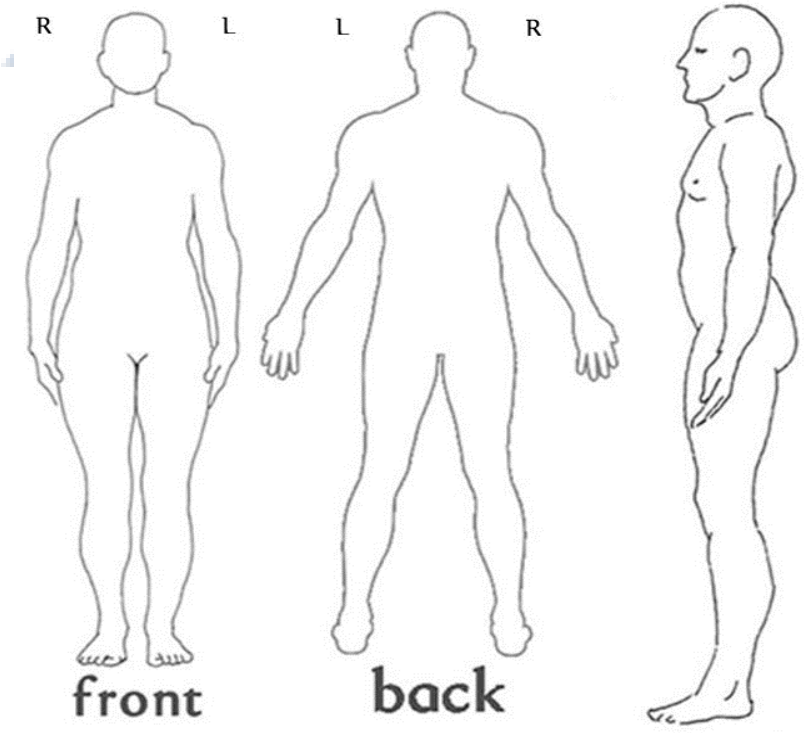
_____

Pleas list areas of the body that are sore/painful; _____

_____

_____

_____



List any other sensations you have been experiencing: _____

_____

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Contraindications: Please check off all contraindications, as they could have negative affects to treatment, if therapist does not know about them:

- ☐ Aneuysm
- ☐ Acute rheumatoid arthreitis
- ☐ Celluitis
- ☐ Systemic or local infection
- ☐ DVT
- ☐ Osteomyelitis
- ☐ Obstructive edema
- ☐ Open wounds
- ☐ Sutures
- ☐ Hematoma
- ☐ Fracture
- ☐ Osteoporosis
- ☐ Anticoagulant therapy
- ☐ Advanced diabetes
- ☐ Hypersensitiviy to skin
- ☐ Pregnant (or possibility you are pregnant)

I, _____, consent to receive physical therapy treatment from Matrix Therapy, LLC. This treatment will involve seom or all of the following: manual techniques, myofascial release, neuromuscular treatment, therapeutic exercises, sensory integration. I understand that these techniques will be explained to me beforehand, and I have the right to refuse treatment at any time. I understand that the risk for injury during treatment is low, but temporary soreness is a common side effect for treatment.

Patient signature

Legal Guardian (if under 18)

I, _____, consent to receive JFB Myofascial Release treatment at Matrix Therapy, LLC. I understand I may experience soreness/headache/nausea after treatment do to release of toxins in the body. This is called a healing crisis. It will last no more than three days, and it will not harm you. It is not caused by the treatment, but is bringing up tension that is already within you.

Patient signature

Legal guardian (if under 18)