Core Restore
123 Inverness Road
Athens, GA. 30606
603-781-7378
info@core-restore.com
www.core-restore.com

Core Restore Client Agreement

Our mutual goal is to heal your body by working together to reteach your body to use the right muscles for the right movements. The clients that have had the most success made an agreement to take accountability in this process for their health and well-being. I am asking you to do the same as spelled out below.

I agree to:

1. **Make my appointments at Core Restore a priority in my life.**
2. **Take responsibility for scheduling my sessions in advance and reschedule only when absolutely necessary.**
3. **Stick with the mutually agreed-upon appointment schedule because MAT/MATRx® has a cumulative effect. MAT/MATRx® is solely dependent on my overall health which determines the number of sessions.**

I understand that:

4. **The MATRx® modality is a process just like exercise and the number of sessions is determined by an infinite number of issues when it comes to healing my individual muscular system.**
5. **The MATRx® has prescriptive rules which require me not to vary from the process. I understand that every pattern's ability to hold is solely dependent upon the muscles within that particular pattern's capability to handle force whether it be chemical, emotional or physical. As each of my patterns increase its stress tolerance my body will be able to handle more and more force.**
6. **If I am inconsistent, this can set me back and prolong the process.**
7. **Recovery is the key to healing the body. Therefore, I am willing to rest and cut back on exercise and activities as necessary to allow my body to heal. The amount that I reduce my exercise is determined on an individual basis. As well, I will comply with my MAT Specialist's instructions to do my reinforcement exercises in order to progress my MAT/MATRx® sessions, including using the CRTS™ as necessary.**

Client signature Date

Core Restore Employee Signature Date

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Health and Medical History and Consent and Release

Name: _____ Date: _____

Date of Birth: _____

Street Address: _____

City/State/Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Email address" _____

Emergency contact: Name / Relationship: _____ Phone: _____

Physical activity should not pose any problem or hazard to the majority of people. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should seek medical advice prior to initiating a fitness program or other change in their physical activity levels. Please check Yes or No.

Yes	No	
☐	☐	1. Are you accustomed to vigorous exercise?
☐	☐	2. Have you ever been diagnosed with Type I or Type II Diabetes?
☐	☐	3. Do you have any reason to suspect that you might now pregnant, or have you been pregnant within the last 3 months?
☐	☐	4. Have you had any major or minor surgery in the past 3 months?
☐	☐	5. Have you been hospitalized in the last 2 years? If so, when and for what reason? _____
☐	☐	6. Are you currently, or have you in the past, ever seen a chiropractor or physical therapist for any condition? If yes, when and for what condition? _____
☐	☐	7. Do you ever experience unexpected shortness of breath, or labored breathing, with or without pain? If yes, describe under what conditions. _____
☐	☐	8. Do you currently, or have you ever, experienced unexplained heart palpitations or been diagnosed with a heart murmur or irregular heartbeat?

☐ ☐ 9. Have you ever been diagnosed with high blood pressure? If yes, when?_____

☐ ☐ 10. Do you know what your blood pressure normally is? If yes, please state _____

☐ ☐ 11. Do you currently smoke? If yes, how many cigarettes per day?_____

☐ ☐ 12. Did you ever smoke? If yes, how long ago did you quit?

☐ ☐ 13. Is there any history of heart disease (prior to age 55) in your immediate family? If yes, explain.

_____

☐ ☐ 14. Do you know your cholesterol levels? If so, please state: _____

☐ ☐ 15. Do you receive regular annual physical exams from your primary care physician? Date of last exam: _____

☐ ☐ 16. Do you have any pain, discomfort?
If you checked "Yes," explain where and how long you have experienced such pain or discomfort.

_____

_____

Are there any other health/medical/injury conditions that your MAT Specialist should be aware of?

_____

Please list any prescription medications or over-the-counter medications or supplements you currently take:

_____

RELEASE / DISCLAIMER

I DO HEREBY ASSUME FULL RESPONSIBILITY FOR ANY AND ALL DAMAGES, INJURIES (INCLUDING DEATH), OR LOSSES THAT I MAY SUSTAIN OR INCUR, IF ANY, WHILE ATTENDING, PRACTICING OR PARTICIPATING IN ANY EXERCISE PROGRAM OR PHYSICAL ACTIVITY OCCURING IN OR ABOUT THE STUDIO. I HEREBY ASSUME FULL RISK, WAIVE ALL CLAIMS AND RELEASE AND HOLD CORE RESORE, LLC, ITS OWNERS, INSTRUCTORS, CONTRACTORS OR EMPLOYEES, INDIVIDUALLY OR OTHERWISE, HARMLESS FOR ANY AND ALL CLAIMS FOR INJURIES OR DAMAGES.

In consideration of my participation in and the use of the Studio's facilities, I hereby release and covenant not to sue the Studio, its owners, instructors, employees or contractors from any and all present claims resulting from ordinary negligence and inherent risk of use of the facilities and equipment of the Studio including but not limited to any loss, injury, damage or liability sustained by me while on or about the premises of the Studio.

By signing and dated below, I certify that I understand the foregoing questions and my answers are true and complete. I also understand that if this information changes in any way in the future, it is my responsibility to notify my MAT Specialist, and that I assume the risk for any changes in my medical condition that might affect my ability to exercise.

Before beginning a new fitness program or other significant change in your physical activity levels, you are advised to consult with your physician or primary health care provider. Only a physician or qualified health care provider is able to diagnose and prescribe treatment for specific health conditions.

I acknowledge that I have read the foregoing statements and fully understand the content thereof, and that if I choose not to consult with my physician or primary health care provider, I do so at my own risk.

_____

Signature Date

_____

Please print name

_____

Parent or legal guardian (if participant is under age eighteen) Date

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Core Restore: Your MAT/MATRx® Session Specifics

I will always address your specific concerns and questions. I am glad to explain any further information you may desire about Muscle Activation Techniques®.

I always take into great consideration each person's individual health history. I require you to fill out a health history questionnaire to help us determine the most cautious way in addressing your current muscular imbalances causing muscular dysfunction. Depending on your health history, we will determine how aggressive and cautious we need to be to minimize the stress placed on your body. One of the many positive benefits is that every time you see a MAT/Rx Specialist, we are raising your muscular threshold (muscle's ability to recover) so your muscles can handle the physical, chemical and emotional stress.

My main goal in a session is to increase your muscular system's ability to recover by identifying muscle weakness and joint limitations to bring stability and strength to the newfound range.

My clients who have had the most success with MAT/Rx have given a time commitment to the process of MAT/Rx and more importantly a commitment to themselves. I like to describe the process as if we are "unpeeling all the layers of an onion to get to the root of the problem," which is result of mechanical failure of muscles from stress (chemical, physical, emotional) trauma and/or overuse/underuse not the pain and tightness associated with the muscular imbalances.

Your health history is a major indicator of how long the process will take you. Most clients start to feel improvement anywhere between 1 to 6 MAT/Rx sessions. Some discomfort is normal, and under certain conditions, some soreness, fatigue or pain can be a positive sign that healing is taking place. The health of your neurological system is affected by the number of car accidents, surgeries, medications, injuries, drugs and alcohol use, how fatigued you are that day, all the traumas you have experienced over your lifetime and how long you had your current condition that brought you to me in the first place. Sufficient rest is very important since your body is under a great deal of stress during the healing process.

MAT/Rx is not a therapeutic massage, physical therapy, or chiropractic. MAT/Rx is non-medical and part of the exercise continuum.

If your body is weak or injured, it makes sense to limit your movement and allow the recovery process to begin with MAT/Rx. This is determined on an individual basis after Client Intake.

If you bruise easily, you may experience the possibility of temporary bruising with some of the palpations.

Some people can feel soreness a day or two later, which can be normal.

Some people experience muscular pain and tightness moving around to other areas of the body.

If bruising or soreness is excessive and you experience unmanageable pain in other areas of your body, please call me immediately as it may signal an underlying problem. The Studio number is 732.502.0100 or my email chris@core-restore.com.

Client Signature: _____ Date: _____

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Core Restore Health History Report

PRINT CLEARLY PLEASE

Name: _____Phone: _____Cell: _____

Complete Address: _____

Email: _____

Sex: _____DOB: _____ Age ____Emergency Contact #: _____

1. Have you ever had? (Please check the ones that apply to you):

- High blood pressure☐
- Heart or circulation disorders☐
- Seizures☐
- Dizzy spells☐
- Diabetes☐
- Degeneration Joint Disease☐
- Arthritis/Osteoarthritis☐
- Scoliosis☐
- Kyphosis☐
- Osteoporosis☐
- Auto Immune Deficiency Disease☐
- Asthma☐
- Direct Injuries/Trauma to Head/Neck☐
- Joint swelling/stiffness☐
- Multiple Sclerosis☐
- Epilepsy/Seizure Disorder☐
- Cancer/Tumors☐
- Chronic Fatigue Syndrome☐
- Fibromyalgia☐
- Thyroid Condition☐
- High Cholesterol☐
- Recent Infections☐
- Neuropathy☐ Location_____
- Smoking History☐
- Back or Neck Problems☐
- Car Accidents/Whiplash☐
- Headaches☐
- Average Hours Sleep per Night_____ #of hours
- Other_____

2). Do you have or in the past suffered from any of the following:

	YES	NO
a. Has your Doctor said or do you have a history of heart problems, chest pain or stroke	☐	☐
b. Has an immediate family member (parent/sibling) had a heart attack, stroke or cardiovascular disease before the age of 55 yrs old?	☐	☐
c. Do you frequently have pains in your heart and/or chest when you do physical activity?	☐	☐
d. Do you lose balance because of dizziness or do you ever lose consciousness?	☐	☐
e. Is your doctor(s) currently prescribing drugs for blood pressure or heart condition? See Quest #3	☐	☐
f. Are you over the age of 65 and not accustomed to vigorous exercise?	☐	☐
g. High Cholesterol or HDL:LDL imbalance	☐	☐
h. Do you currently smoke? Cigarette, cigar, pipe smoking How Much How Long	☐	☐
i. Obesity	☐	☐
j. Asthma or Breathing trouble	☐	☐
k. Have you ever had a stroke or heart attack?	☐	☐
l. Are you a male greater than 45 yrs old? Are you a female greater than 55 yrs old?	☐	☐
m. (Females) Pregnancy currently or within last 12 months	☐	☐
How many children have you had?		
n. Learning disabilities or cognitive challenges	☐	☐
o. Do you consume any alcoholic beverages? (Beer, wine, liquor, etc.)	☐	☐
Please indicate in ounces how much alcohol you consume weekly (include beer, wine, liquor)		oz
p. Do have difficulty swallowing food or chewing food?	☐	☐
q. Is there any reason not mentioned thus far to preclude you from regular exercise activity?	☐	☐

3). Please elaborate here if you checked “yes” for letters a, c, d, j, n, and o.

_____
_____
_____
_____
_____
_____
_____
_____

4) Please identify any diagnosed diseases in the boxes below:

Diagnosed Diseases *X-Rays, MRI Reports, CT Scans reports can be provided*	**Initial Diagnosis Made**
Orthopedic (i.e. Spinal fusion, Knee joint replacement)	
Metabolic (i.e. Diabetes, Hypothyroid)	
Neurological (i.e. Stroke, Parkinson's)	
Dental Work (Braces/Night Bite Plates, Appliances, orthodontics)	

5). Do you have any METAL or SILICONE anywhere in your body: pins/plates post-fracture, pacemaker, implants, major dental work?

_____

_____

6). Have you had cosmetic/plastic surgeries? Please describe below: (include Botox)

_____

_____

7). If you have elective surgeries, within what time frame where the surgeries?

1-2yrs☐ 3-4yrs☐ 5-6yrs☐ more than 7 yrs b/w each surgery☐

8). Please list any current medications, self prescribed medication, or dietary supplements that you are taking:

_____

_____

_____

_____

9). Do you wear orthotics or a mouth guard at night?

_____

10). Do you wear heels or flip-flops? Yes or No. Describe typical footwear:

☐ ☐

_____

11). Do you use a foam roller in your workout routine? Yes or No?

☐ ☐

12). (Women) If you still menstruate or you are currently menstruating or close to having your period? Yes or No

☐ ☐

13). Have you had steroid or cortisone shots? How many different shots, how many years ago and where did you have the shots in your body?

_____

_____

14). Do you have any abnormal trouble with vision? Yes or No / Hearing? Yes or No

☐ ☐ ☐ ☐

Please complete the following information as completely and thoroughly as possible. *No check marks, explain the issue(s).*
This is an extremely important section of this questionnaire.

15). Trauma/Injury/Surgery History (Every significant physical pain you have experienced) includes even what you might consider minor, non-medically treated injuries.

Body Part	1-18 years	19 - 29 years	30 – 45 years	46 - 60 years	60 + years
Head/Jaw i.e. Clicking jaw, concussion,					
Cervical/ Neck i.e. whiplash,					
Thoracic/ Mid back					
Lumbar/ Low back					
Abdominals/					

Ribs Hernia					
Pelvis/Hips Femur/Thigh					
Shoulder/ Scapulae/ Rotator cuff					
Elbow i.e. tennis elbow					
Arm					
Wrist/Hand Fingers *Carpal Tunnel*					
Body Part	1 -18 years	19 - 29 years	30 – 45 years	46 - 60 years	60 + years
Knees Patella, ACL, Tendonitis					
Ankles/Feet					

16). What is your occupation?
Physical - Sitting, Standing, Positional How Long/Day? 7-8 hours
Emotional - Hi Pressure, Boring, Intermittently Hi & Lo Pressure
Stressful- No How long under this stress? In years_____
What are your daily demands at your occupation?

17). What type of self care do you do? C for Current and P for Past

- Massage _____
- Acupuncture _____
- Rolfing _____
- Chiropractic _____
- Yoga _____
- Heating Pads_____
- Stretching_____
- Active Release Technique _____
- Reiki _____
- Cranio-Sacral _____
- Physical Therapy _____
- Pilates _____
- Ice_____
- Magnets_____

18). **Please prioritize the severity (#1 is the worst or greatest concern) of your current physical pain/discomfort.**

#1	
#2	
#3	
#4	

19). Exercise History: ***(Past within the last 2 years)***

	Cardio Equipment ***(List the type of Machines)***	Times per week	How Long?	Intensity: Subjective Scale (1-10)	Current or Past
Walking					
Running					
Biking					
Swimming					
Cardio Equipment	A. B. C.				
Strength Training				Sets: Reps:	
Crossfit/Power Training					
Resistance/Endurance Training					
Stretching (circle) **YES NO**	**Passive or Active**				
Other:					

20). If you feel that you are experiencing unusual levels of stress in one or more of the following areas: Please circle 'Yes" if not circle "No":

Home	Yes ☐ No ☐
Work/School	Yes ☐ No ☐
Financial	Yes ☐ No ☐
Relational	Yes ☐ No ☐

21). Nutritional Status

Type of Diet	
Food Allergies	
Are you a conscious eater?	
Do you eat out more than you eat at home?	
How many times do you eat a day?	
What are the times you eat?	

22). Are you sleeping well? _____

23). What physical activities and/or physical positions can you not perform without discomfort or significant tension? (I.e. kneeling down, reaching overhead)

#1	
#2	
#3	
#4	
#5	

24). What have you found to be positions of relief or things you do to manipulate your own body during the day to deal with any pain or discomfort?

_____
_____
_____

25). Please list and rate the goals for your movement/exercise program as far as how close or far you are from reaching them right now; Circle a number for each goal listed.

YOUR GOALS	Far				Half	Way				Done