CAROLINASCHIROPRACTIC
AND SPINAL REHAB

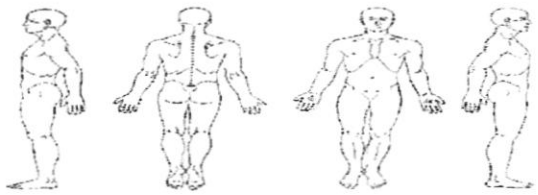
Active Release Technique (ART) Intake

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

Have you had ART before? ____Yes ____No **If yes, for which area and how long ago?** _____

_____

Please circle the area(s) of discomfort:



Left Back Front Right

Describe your pain (Circle): Sharp Dull Numbness Tingling Burning Tight Stiff Achy

Any referral pain? ____Yes ____No **If yes, which area(s)?** _____

When did this start and how?_____

Have you had any injuries or previous pain to the area? _____

Have you had any surgeries? ____Yes ____No **If yes, please list surgeries and dates:** _____

_____

Please list any medications you are currently taking:_____

Have you ever been diagnosed with blood clots/ clotting disorder/ DVT? ____Yes ____No

Do you bruise easily? ____Yes ____No **What do you do for a living?** _____

Please list any hobbies/ activities you enjoy:_____

Do you exercise regularly? ____Yes ____No **If yes, please list type of exercise and frequency:**

_____

Has this affected your ability to work? ____Yes ____No **If yes, how so?**_____

By signing this, I understand that Active Release Technique is a soft tissue treatment system and will therefore be treating muscles, ligaments, and nerves. I am aware that treatment of these tissues may result in soreness or temporary discomfort. I am aware that a history of DVT or clotting disorders is a contraindication to treatment. The possible benefits of Active Release Technique include symptom reduction/ relief, decreased muscle tension, and improved function of the structure treated.

Signature:_____ **Date:**_____