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New Patient Health History Form

It is my hope that I can assist you with your current and future health concerns. During the course of your examination and treatments, please feel free to comment, ask questions, and provide me with feedback. I feel that the more you know and understand about yourself, the more effective your treatments will be. I look forward to helping you achieve optimal health and well-being.

Patient Information

***Required Fields**

*Date: (dd/mm/yy) _____/_____/_____ Date & Time of first appointment: _____

*First Name : _____ *Last Name : _____

Street Address: _____

City: _____ Province/State: _____ Country: _____

Postal/ZIP Code: _____ Email: _____

*Home Phone: _____ Work Phone: _____ Cell Phone: _____

NOTE: It is important that at least one phone number be provided so that we are able to reach you for scheduling your care.

*Age : _____ *Birthdate : (dd/mm/yy) _____/_____/_____ Sex: ○ Male ○ Female

Occupation: _____

Place of Birth: _____ Marital Status: _____ Number of Children: _____

If the patient is a child, give the parent's names:

Mother: _____ Father: _____

NOTE: for patients 12 and under please use the Children's Health Questionnaire

Closest relative: _____ Phone # of closest relative: _____

Medical Doctor: _____ Doctor's telephone: _____

How did you hear about Matrix Repatterning? Please be specific: _____

Chief reason for seeking care: _____

Length of time for current condition: _____ Other forms of therapy for this condition: ○ Current ○ Previous

Please specify: _____

Motor vehicle accident: ○ Yes ○ No If yes, date: (dd/mm/yy) _____/_____/_____ ○ Driver ○ Passanger

Work-related injury/accident: ○ Yes ○ No If yes, date/brief description: _____

_____

_____

Surgeries (include dates): _____

_____

Fractures/sprains (include dates): _____

_____

Hardware/Artificial Joints: ○ Yes ○ No Please specify: _____

Other injuries (include dates): _____

_____

_____

Major illnesses (include dates): _____

_____

How is your general health? _____ Exercise (type/times per week): _____

_____

Activities or positions that aggravate your symptoms. _____

Do you feel you are under excessive stress? _____ What are the things that you find stressful? _____

_____

Do you have regular sleeping habits? ○ Yes ○ No How many hours/night? _____

Current Medications: _____

_____

_____

_____

_____

Additional relevant information: _____

_____

_____

_____

_____

Health History

Please select those conditions or symptoms which you currently have, have had previously, occasionally or have never had.

C = Current P = Previous O = Occasionally N = Never

C	P	O	N	CARDIOVASCULAR
○	○	○	○	Angina
○	○	○	○	Bleeding disorders
○	○	○	○	Ankle swelling
○	○	○	○	Heart disease
○	○	○	○	Heart murmur
○	○	○	○	High blood pressure
○	○	○	○	Irregular heartbeat
○	○	○	○	Low blood pressure
○	○	○	○	Pacemaker
○	○	○	○	Poor circulation
○	○	○	○	Stroke

C	P	O	N	SKIN
○	○	○	○	Bruise easily
○	○	○	○	Bleed easily
○	○	○	○	Dryness
○	○	○	○	Eczema
○	○	○	○	Itching
○	○	○	○	Psoriasis
○	○	○	○	Rashes
○	○	○	○	Sensitivities
○	○	○	○	Varicose veins

C	P	O	N	INFECTIONS
○	○	○	○	AIDS
○	○	○	○	Hepatitis
○	○	○	○	Herpes
○	○	○	○	HIV
○	○	○	○	Tuberculosis
○	○	○	○	Infectious skin conditions *

* Specify: _____

_____

C	P	O	N	EYE, EAR, NOSE AND THROAT
○	○	○	○	Difficulty swallowing
○	○	○	○	Earache
○	○	○	○	Hearing Loss
○	○	○	○	Hoarseness
○	○	○	○	Nosebleeds
○	○	○	○	Ear noises
○	○	○	○	Sinus pain
○	○	○	○	Vision problems

C	P	O	N	MEN
○	○	○	○	Decreased urinary flow
○	○	○	○	Dribbling after urination
○	○	○	○	Erectile dysfunction
○	○	○	○	Waking up to urinate
○	○	○	○	Inability to control bladder

C	P	O	N	WOMEN
○	○	○	○	Backache
○	○	○	○	Breast problems
○	○	○	○	Bladder dysfunction
○	○	○	○	Caesarian section
○	○	○	○	Cramps
○	○	○	○	Fibroids
○	○	○	○	Menopausal symptoms
○	○	○	○	Mid cycle pain
○	○	○	○	Ovarian cysts
○	○	○	○	Painful intercourse
○	○	○	○	Painful menstruation
○	○	○	○	PMS
○	○	○	○	Yeast infection
○	○	○	○	Pregnancy*

*If currently Pregnant, due date:

_____

C	P	O	N	GENERAL
○	○	○	○	Alcohol/drug problem
○	○	○	○	Allergies
○	○	○	○	Arthritis
○	○	○	○	Blood in urine
○	○	○	○	Cancer
○	○	○	○	Constipation
○	○	○	○	Convulsions/Seizure
○	○	○	○	Diabetes
○	○	○	○	Digestive problems
○	○	○	○	Dizziness
○	○	○	○	Esophageal reflux
○	○	○	○	Fainting
○	○	○	○	Fatigue
○	○	○	○	Fibromyalgia
○	○	○	○	Gall bladder problems
○	○	○	○	Headache
○	○	○	○	Hernia
○	○	○	○	Insomnia/ sleep problems
○	○	○	○	Kidney problems
○	○	○	○	Liver problems
○	○	○	○	Mental disorders
○	○	○	○	Nervousness/depression
○	○	○	○	Neuralgia
○	○	○	○	Osteoporosis
○	○	○	○	Spinal curvature

C	P	O	N	RESPIRATORY
○	○	○	○	Apnea
○	○	○	○	Asthma
○	○	○	○	Chronic cough
○	○	○	○	Difficult breathing
○	○	○	○	Snoring

Signature: _____ Date: (dd/mm/yy) _____/_____/_____

Patient's Name: _____