MATRIX REPATTERNING
NEW PATIENT FORM

Christine Veres, BSc, RMT, CMRP
Registered Massage Therapist
Certified Matrix Repatterning Practitioner
39 Marksam Road, Guelph, Ontario N1H 1X1
(519) 763-2608 soulcentricwellness21@gmail.com

Date (MM/DD/YY): _____

Name: _____
Address: _____
_____
Date of Birth: (MM/DD/YY) _____
Current Age: _____

Cell Phone: _____
Home Phone: _____
Business Phone: _____
Email Address: _____
Occupation: _____

Primary Physician: _____
Physician's Address: _____
Physician's Telephone: _____

Emergency Contact: _____
Relationship: _____
Phone Number: _____

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

Chief reason for seeking treatment: _____

Length of time of current condition: _____

Have you received any other form of therapy for this condition: ____ Current _____ Previous

Please specify: _____

Motor Vehicle Accident: ____ Yes _____No If yes, date:_____

Work-related Injury/accident: ____ Yes _____No If yes, date:_____

Surgeries including dates: _____
_____

Fractures/Sprains including dates: _____
_____

Hardware/Artificial Joints: ____ Yes _____No

If yes, please specify: _____

Other injuries including dates: _____
_____

Major illnesses including dates: _____
_____

How is your general health? _____

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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 most stressful? _____

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

Current medications and what they treat: _____

_____

_____

Additional relevant information: _____

_____

_____

_____

HEALTH HISTORY

Please select those conditions or symptoms that 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 heart beat
_ _ _ _ Low blood pressure
_ _ _ _ Pacemaker
_ _ _ _ Poor circulation
_ _ _ _ Stroke

C P O N (Infections)

_ _ _ _ AIDS
_ _ _ _ Hepatitis
_ _ _ _ Herpes
_ _ _ _ HIV
_ _ _ _ Infectious skin conditions
_ _ _ _ Tuberculosis

C P O N (Eye, Ear, Nose, Throat)

_ _ _ _ Difficulty swallowing
_ _ _ _ Earache
_ _ _ _ Hearing loss
_ _ _ _ Hoarseness
_ _ _ _ Nosebleeds
_ _ _ _ Ear noises
_ _ _ _ Sinus pain
_ _ _ _ Vision problems

C P O N (Skin)

_ _ _ _ Bruise easily
_ _ _ _ Bleed easily
_ _ _ _ Dryness
_ _ _ _ Eczema
_ _ _ _ Itching
_ _ _ _ Psoriasis
_ _ _ _ Rashes
_ _ _ _ Sensitivities
_ _ _ _ Varicose veins

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HEALTH HISTORY (CONTINUED)

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

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

C P O N (General)

_ _ _ _ Alcohol/drug problem
_ _ _ _ Allergies
_ _ _ _ Arthritis
_ _ _ _ Blood in urine
_ _ _ _ Cancer
_ _ _ _ Constipation
_ _ _ _ Convulsions/Seizures
_ _ _ _ Diabetes
_ _ _ _ Digestive problems
_ _ _ _ Dizziness
_ _ _ _ Esophageal reflux
_ _ _ _ Fainting
_ _ _ _ Fatigue
_ _ _ _ Fibromyalgia
_ _ _ _ Gall Bladder problems
_ _ _ _ Headaches
_ _ _ _ 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

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
_ _ _ _ Pregnancy*
_ _ _ _ PMS
_ _ _ _ Yeast Infection

*If currently pregnant, due date: _____

Signature: _____

I give Christine Veres permission to contact me by email. _____