



**SOUL
CENTRIC
WELLNESS**

**MATRIX REPATTERNING
NEW PATIENT FORM**

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Date (MM/DD/YY): _____

Name: _____

Cell Phone: _____

Address: _____

Home Phone: _____

Date of Birth: (MM/DD/YY) _____

Business Phone: _____

Current Age: _____

Email Address: _____

Occupation: _____

Primary Physician: _____

Emergency Contact: _____

Physician's Address: _____

Relationship: _____

Physician's Telephone: _____

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 (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: _____

C P O N (Respiratory)

- Apnea
- Asthma
- Chronic cough
- Difficult breathing
- Snoring

Signature: _____

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