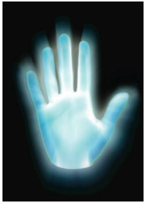

Newmarket Massage Therapy Clinic

16700 Bayview Ave., Suite 213, Newmarket ON L3X 1W1 T: 905.967.0467 E: newmarketrmt@gmail.com

New Patient Form

It is our hope that we 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 us with feedback. We feel that the more you know and understand about yourself, the more effective your treatments will be. We 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 at NMTC: ________________________________

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: ______________________________

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: ______________________________

____

____

____

____

____

____

Patient's Name: ______________________________

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
○	○	○	○	Pregnancy*
○	○	○	○	PMS
○	○	○	○	Yeast infection

*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: ______________________________