Matrix Repatterning Patient Entrance Form

Name:____

Birthdate:____

Address:____

____

Phone number:_______________________________________
(number you preferred to be reached at)

Email address:______________________________________

Emergency Contact - Name:___________________________
Emergency Contact – Number:_________________________

Medical Doctor:
Name:____
Phone:____
Address:____

Previous chiropractic care: **Yes** **No**

Previous therapies: (please list)____________________
____

Were you referred to us: **Yes** **No**
If so, by whom? ____________________________________
(please note, we only ask so that we are able to thank them for their referral. Word-of-mouth referral is the main way I build my practice and I very much appreciate any referrals I receive!)

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PATIENT HEALTH HISTORY

Patient Name:____
Date:____

Trauma:

Motor Vehicle Collisions:____________________________________
Date:____
Injuries sustained:____

Date:____
Injuries:____

Surgery/hospitalizations:_____________________________________

____
Falls/Accidents:____

____

Fractures/Sprains:____

____
Head injuries/concussions:____________________________________
____

Allergies: (medications or other)____________________________

____
Dental Work: (root canals, extractions, fillings, other)
____

Medications: (presently taking and for what)

Digestive: (constipation, diarrhea, ulcers, food sensitivities, irritable bowel, acid reflux, or other)
____

____

Patient Name:____
Date:____

Cardiovascular: (heart conditions)

Blood pressure: normal high low
Cholesterol: normal high
History of stroke or heart attack: yes no
Family history:____
____

Women: (menstrual pain, dysfunction, endometriosis, hysterectomy, cysts, hormonal imbalance)

Pregnancy: yes no how many:
Complications:____
____

Men: (prostate, pelvic pain, other)________________________________

Headaches: (migraines, tension-type, jaw/TMJ)__________________

Sleep Disorders:____

Ear/Eye/Nose/Throat: (tinnitus, pain, sinus infections, other)
____

Significant Stress:____

Decreased Energy: yes no

Frequent Colds: yes no

Thyroid Imbalance: yes no

Family Medical History Conditions:________________________________

Other: (anything not addressed above)
____