Gleeson Clinic 1304 Victoria Ave., Thunder Bay, ON P7J 1C2 807-623-5531 Tamara J Brady, RMT, CMRP

Matrix Repatterning
Additional Confidential Health History - Page 1

Thank you for your time and consideration to share additional details of your health. This helps to better understand your condition and serves as a baseline of your current condition and symptoms. Massage Therapists do not diagnose illness, disease or any physical/mental disorder nor do we prescribe any medical treatment or perform chiropractic adjustments. Massage Therapy is not a substitute for medical examination or diagnosis and it is recommended you see a medical doctor for that service. Initial:________

Name: ____Age: _____Date: ___________________
Where did you hear about Matrix Repatterning? ___________________________
Goals for seeking treatment: ____

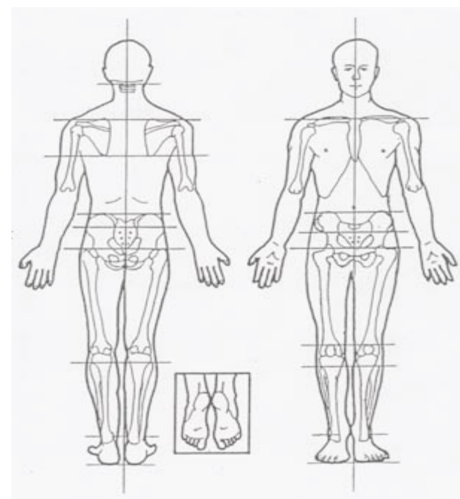
Presenting Condition(s): Please list your concerns in order of priority:

	SYMPTOM/ CONDITION: DESCRIBE	SEVERITY (Scale: 0-10)	IS IT CONSTANT?	WHEN DID IT START?	WHAT MAKES IT BETTER?	WHAT MAKES IT WORSE?
P1.						
P2.						
P3.						
P4.						
P5.						

Other Practitioners / Treatments:

Laboratory/Imaging:

Lifetime Health History (Hx):
Additional Details of any Impact Injuries including: Falls, Motor vehicle accidents, Work or Sports injuries, Fractures, Childhood injuries, Concussions... Include approximate dates.



Please indicate areas of concern

Impact Sports:

Dental Work:

Patient's Childbirth Hx:

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Additional Confidential Health History - Page 2

Name: ____ Date: __________________

Emergency Contact: _____________________________ Relationship: ________________________

General health: Poor fair good excellent

Current level of stress: _____ /10
Stress Issues:

How would you rate your activity level: ______/ 10 (1- sedentary, move as little as possible, drive, take elevators. 10- always moving, walk/take stairs whenever possible.)

Physical limitations due to your current condition: (eg. P1 - Left knee pain starts at 10 min walking: stop due to pain at 20 min. Can't kneel. No longer play basketball.)

Sleep: Hours/night_____ # times waking______ reason for waking_________________
What position do you sleep in? Back Right Side Left Side Stomach
Please check all that apply:
__Snoring ___CPAP ____Clenching/Grinding teeth ___mouth/night guard ___jaw pain ___Clicking or clunking of jaw Describe:_______________________

Do you ever get Tension Headaches? Yes No Intensity: ____/10 to ___ /10 (0-none 10-unbearable)
Caused by: ___________________
Describe location on head:
How often? _______ times per day / wk / month / yr
How long do they last?

Migraine Headaches? Yes No Intensity: ____/10 to ___ /10 (0-none 10-unbearable)
Caused by: _______________________
Describe location in head:
How often? _______ times per day / wk / month / yr
How long do they last?

Tinnitus / ringing or noise in ears? Yes No
Is it constant?
Severity: _____/10 at best _____/10 at its worst

Acid Reflux? Yes No ___Managed with Diet ___Managed with Medication

If female, PMS cramping? Yes No How long does it last?_________

Bladder continence or Leaking when you cough, sneeze, laugh, jump or run? (please circle)

Current Health Goals?

Additional Information?