MATRIX HEALTH SOLUTIONS
Expanding the Horizons of Well-being

www.matrixhealth.solutions email: reception@matrixinstitute.net Phone: 647-335-MTRX (6879) Toll-free: 1-877-905-7684

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 our services, the more effective your treatments will be. We look forward to helping you achieve optimal health and well-being.

I have watched the Introductory Video: ◯ Yes ◯ No I found the Introductory Video helpful: ◯ Yes ◯ No

Patient Information

* **Required Fields**

Date*: _____/_____/_____
Day Month Year

First Name*: _____ Last Name*:_____

Street Address: _____

City: _____ Province/State:_____ Country:_____

Postal/ZIP Code: _____ Place of Birth _____

Age*: _____ Birth date*: _____/_____/_____ Sex: ◯ Male ◯ Female

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.

.
Email Address**:** _____ Would you like to join our mailing list? ◯ Yes ◯ No

Occupation: _____

Employer: _____ Marital Status: _____ Number of Children:_____

If the patient is a child*, give the parent's names:

Mother: _____ Father: _____

*NOTE: For patients 12 and under that are seeing Dr. Roth specifically please use the **Children's Health Questionnaire**

Closest relative: _____ Phone # of closest relative: _____

Medical Doctor: _____ Doctor's telephone: _____

How did you hear about Dr. Roth/Matrix Health Solutions?

_____

Chief reason(s) for seeking care at Dr. Roth/Matrix Health Solutions: _____

Length of time for current condition: _____ Have you received other forms of therapy for this condition?: ◯Current ◯ Previous

Please specify: _____

Motor vehicle accident: ◯ Yes ◯ No If yes, date(s): _____

Work-related injury/accident : ◯ Yes ◯ No If yes, date(s): _____

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? _____

Exercise (type/times per week): _____

Activities or positions that aggravate your symptoms. _____

Do you feel you are under excessive stress? _____ What are the things you find stressful? _____

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

Current Medications: _____

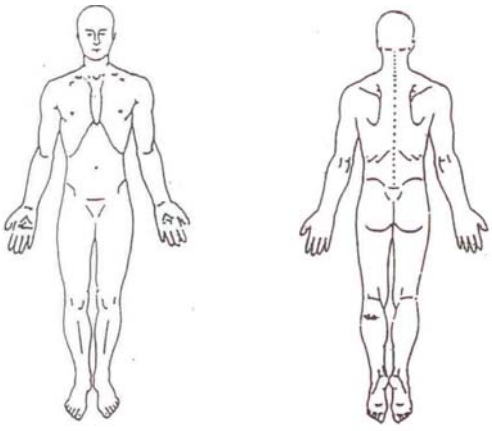
_____

Additional relevant information: _____

_____

_____

Do you have any internal pins, wires, plates, artificial joints, pacemaker or other surgically implanted parts? If yes, please list and/or indicate location by placing an "X" on the diagrams below:



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
◯	◯	◯	◯	Low blood pressure
◯	◯	◯	◯	Irregular heartbeat
◯	◯	◯	◯	Pacemaker
◯	◯	◯	◯	Poor circulation
◯	◯	◯	◯	Stroke
◯	◯	◯	◯	Varicose veins

C	P	O	N	SKIN
◯	◯	◯	◯	Bruise easily
◯	◯	◯	◯	Bleed easily
◯	◯	◯	◯	Dryness
◯	◯	◯	◯	Eczema
◯	◯	◯	◯	Itching
◯	◯	◯	◯	Psoriasis
◯	◯	◯	◯	Rashes
◯	◯	◯	◯	Dermatitis
◯	◯	◯	◯	Open sores
◯	◯	◯	◯	Warts
◯	◯	◯	◯	Burns

C	P	O	N	INFECTIOUS CONDITIONS
◯	◯	◯	◯	AIDS
◯	◯	◯	◯	Hepatitis
◯	◯	◯	◯	Herpes
◯	◯	◯	◯	HIV
◯	◯	◯	◯	Tuberculosis
◯	◯	◯	◯	Infectious skin conditions:

C	P	O	N	EYES, EARS, NOSE, 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
◯	◯	◯	◯	Yeast infection
◯	◯	◯	◯	PMS
◯	◯	◯	◯	Pregnancy*

*If currently pregnant, due date: _____

C	P	O	N	GENERAL/OTHER
◯	◯	◯	◯	Alcohol/drug problem
◯	◯	◯	◯	Allergies
◯	◯	◯	◯	Arthritis
◯	◯	◯	◯	Blood in urine
◯	◯	◯	◯	Cancer*

*Location/Type: _____

◯	◯	◯	◯	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

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	RESPIRATORY
◯	◯	◯	◯	Asthma
◯	◯	◯	◯	Bronchitis
◯	◯	◯	◯	Emphysema
◯	◯	◯	◯	Chronic cough
◯	◯	◯	◯	Shortness of breath
◯	◯	◯	◯	Snoring
◯	◯	◯	◯	Sleep Apnea

C	P	O	N	DIGESTIVE SYSTEM
◯	◯	◯	◯	Constipation
◯	◯	◯	◯	Crohn's disease
◯	◯	◯	◯	Colitis
◯	◯	◯	◯	Irritable bowel syndrome
◯	◯	◯	◯	Ulcer
◯	◯	◯	◯	Gall bladder problems
◯	◯	◯	◯	Sinus pain
◯	◯	◯	◯	Vision problems
◯	◯	◯	◯	Esophageal reflux

C	P	O	N	MUSCLE/JOINT PAIN
◯	◯	◯	◯	Neck
◯	◯	◯	◯	Upper back
◯	◯	◯	◯	Mid back
◯	◯	◯	◯	Low back
◯	◯	◯	◯	Shoulder
◯	◯	◯	◯	Elbow
◯	◯	◯	◯	Wrist/hand
◯	◯	◯	◯	Hip
◯	◯	◯	◯	Knee
◯	◯	◯	◯	Ankle/Foot

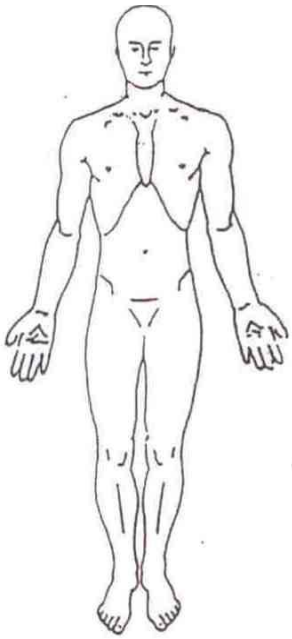
FAMILY HISTORY:

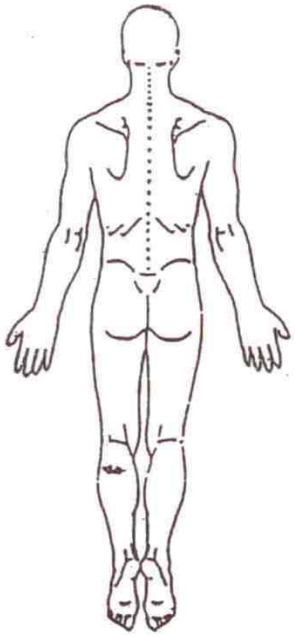
C	P	O	N	
◯	◯	◯	◯	Arthritis
◯	◯	◯	◯	Hemophilia
◯	◯	◯	◯	Fibromyalgia

C	P	O	N	
◯	◯	◯	◯	Scoliosis
◯	◯	◯	◯	Osteoporosis
◯	◯	◯	◯	Heart conditions

C	P	O	N	
◯	◯	◯	◯	Chronic Fatigue
◯	◯	◯	◯	Osteoporosis
◯	◯	◯	◯	Cancer

Please indicate where you are experiencing any pain, joint and muscle stiffness, or numbness/tingling on the diagrams below:





Patient's Name: _____