(https://www.matrixhealth.solutions)

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Profile Information — Step 1 of 3

You are completing the intake form: **New Patient Form** for **

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.

If you haven't already seen it - please watch our Introductory Video before filling out this form.

Please remember to wear or bring stretchy, comfy clothes to your appointment, e.g. track pants or leotards.

Only staff members can edit this information on an intake form.

First Name – *Required*

First Name

Last Name – *Required*

Last Name

Prefix / Title

Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Mobile Phone

CA

A mobile phone is required if you would like to receive SMS appointment reminders.

Home Phone

CA

Country

Canada

Street Address

Suite Number (i.e. Suite #100)

City

Province

Postal / Zip

Date of Birth

Gender

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Sex

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Personal Health Number

Occupation

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

How did you hear about us?

How did you hear about us?

Who were you referred to?

Matrix Health Solutions

Continue

Questionnaires — Step 2 of 3

You are completing the following intake forms: New Patient Form

New Patient Form

New Client Form

Chief reason for seeking care at Matrix Health Solutions

Length of time for current condition(s)

Have you received other forms of therapy for this condition?

☐ Yes ☐ No

If yes, please specify and include names of practitioners

What aggravates your symptoms?

What relieves your symptoms?

Health History

Please select those conditions or symptoms which you currently have or which you have had previously.

Cardiovascular

☐ Angina

☐ Bleeding disorders

☐ Ankle swelling

☐ Heart disease

☐ Heart murmur

☐ High blood pressure

☐ Irregular heartbeat

☐ Low blood pressure

- [ ] Pacemaker
- [ ] Poor circulation
- [ ] Stroke

Eye, Ear, Nose, Throat

- [ ] Difficulty swallowing
- [ ] Earache
- [ ] Hearing Loss
- [ ] Hoarseness
- [ ] Nosebleeds
- [ ] Ear noises
- [ ] Sinus pain
- [ ] Vision problems

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

Skin

- [ ] Bruise easily
- [ ] Bleed easily
- [ ] Dryness
- [ ] Eczema
- [ ] Itching
- [ ] Psoriasis
- [ ] Rashes
- [ ] Sensitivities
- [ ] Varicose veins

Men

- [ ] Decreased urinary flow
- [ ] Dribbling after urination
- [ ] Erectile dysfunction
- [ ] Waking up to urinate
- [ ] Inability to control bladder

Women

- [ ] Backache
- [ ] Breast problems
- [ ] Bladder dysfunction
- [ ] Caesarian section
- [ ] Cramps
- [ ] Fibroids
- [ ] Menopausal symptoms
- [ ] Mid cycle pain
- [ ] Ovarian cysts
- [ ] Painful intercourse
- [ ] Painful menstruation
- [ ] Yeast Infection
- [ ] Pregnancy*
- [ ] PMS

*If currently pregnant, what is your due date?

Childbirth history

Respiratory

☐ Apnea ☐ Asthma ☐ Chronic cough ☐ Difficult breathing ☐ Snoring

Infections

☐ AIDS ☐ Hepatitis ☐ Herpes ☐ HIV ☐ Infections skin conditions ☐ Tuberculosis

Motor vehicle collision(s)

☐ No ☐ Yes

If yes, indicate dates of collision(s)

Work-related injury / accident

☐ No ☐ Yes

If yes, indicate date(s) of injury / accident

Surgeries, including dates

Dental history including braces, implants, extractions, etc.

Fractures / Sprains, including dates

Falls / Impacts

Other injuries including dates

Hardware / Artificial Joints

☐ Yes ☐ No

If yes, please specify.

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 that you find stressful?

Eating Habits

Do you have regular sleeping habits?

☐ Yes ☐ No

How many hours?

Current Medications

Supplements / Medication

Health Priorities / Goals

Additional relevant information

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Consents — Step 3 of 3

You are completing the following intake forms: New Patient Form

New Patient Form — Consents

Medical Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree – *Required*

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hour notice for any cancellations or changes to your appointment. Patients who provide less than 24 hour notice, or miss their appointment, will be charged a cancellation fee of $60.

- [ ] I am aware of the Cancellation Policy. – *Required*

Fee Schedule

I have read and understand the fee schedule.

- [ ] I agree to pay for services at the conclusion of each and every visit. – *Required*

Introductory Video

- [ ] I agree to watch the introductory video prior to my initial appointment. – *Required*

Please check that all required questions have been answered.

Submit Intake Form