Matrix Repatterning
Additional Confidential Health History - Page 1

This additional information is to help your practitioner understand your condition and most efficiently treat you. It will also serve as a baseline of your current condition and symptoms to later reference. We appreciate your time and consideration.

Name: _____Age: _____Date: _____

Reason for seeking treatment: _____

Presenting Condition(s):

SYMPTOM/ CONDITION	SEVERITY (Scale: 1-10)	ONSET DURATION	AGGRAVATING FACTORS	RELIEVING FACTORS	PREVIOUS OCCURRENCE
1.					
2.					
3.					
4.					
5.					

Other Practitioners / Treatments:

Laboratory/Imaging:

Health Hx: Please include dates.
MVC's (motor vehicle collisions):

Work-related Injuries:

Sports Injuries:

Falls/ Impacts:

Fractures:

Dental Hx:

Hospitalizations:

Patient's Childbirth Hx:

Childhood Health Hx:

Family Hx:

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Name: _____ Date: _____

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.)
Exercise (type and times/week):

Physical limitations due to your current condition:

Duration of activity prior to onset of pain to discomfort: _____(eg. sit still/stand/run/work...)
Activity:_____

Duration of activity prior to having to stop or change activity due to pain or discomfort: _____(eg. sit still/stand/run/work...) Activity:_____

Sleep: Hours/night_____ # times waking_____ reason for waking_____
Do you snore? Yes No
Use a CPAP? Yes No
Clenching/Grinding teeth? Yes No
Mouth / night guard? Yes No

Tension Headaches? Yes No
Where on your head?
What causes them?
How often? _____ times per day/wk/month
How long do they last?

Migraine Headaches? Yes No
Where on your head?
What causes them?
How often? _____ times per day/wk/month
How long do they last?

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

Have Acid Reflux? Yes No

Bladder continence / Leaking when you cough, sneeze, laugh, jump or run? (please circle)
Regular bowel movements? Yes No
Frequency: Daily or Other_____
Consistency? Normal or Other: _____
Any hardware / artificial joints / implants / IUD / mesh / pacemaker ?

What are your Current Health Goals?