Matrix Massage
229 Frederick St.
Kitchener, ON N2H 2M7

MARY KOLOSOWSKI
Registered Massage Therapist • Certified Matrix Repatterning Practitioner • Health History Form

Name_____ Tel:_____
Address_____ Cell:_____
_____ Date of Birth____- ____- _____
Occupation_____ Email _____
What is your primary complaint?_____

| | | |
|---|---|---|
| Cardiovascular/Circulatory<br>☐ High Blood Pressure<br>☐ Low Blood Pressure<br>☐ Heart disease<br>☐ Stoke/CVA<br>☐ CCHF<br>☐ Pacemaker/other device<br>☐ Heart attack<br>☐ Phlebitis<br>☐ Raynaud's disease<br>Respiratory<br>☐ Asthma<br>☐ Emphysema<br>☐ Bronchitis<br>☐ Chronic cough<br>☐ Shortness of breath<br>Digestive<br>☐ Colitis<br>☐ Celiac disease<br>☐ Gastroesophageal reflux<br>Other_____ | Neurological<br>☐ Vision loss/problems<br>☐ Hearing loss/problems<br>☐ Loss of sensation in extremities ie.Hands/feet<br>Other Conditions<br>☐ Diabetes Onset_____<br>☐ Cancer<br>☐ Epilepsy<br>☐ Arthritis/ RA/Osteo<br>☐ Allergies_____<br>☐ Skin conditions_____<br>☐ Bruise easily/hemophilia<br>☐ Multiple Sclerosis<br>☐ Fibromyalgia<br>☐ Systemic Lupus Erythematosis<br>☐ Hernia<br>☐ osteoporosis<br>Women<br>☐ Pregnant :due_____ | Infections<br>☐ Hepatitis<br>☐ TB<br>☐ HIV<br>☐ Skin conditions<br>Body Pain<br>☐ Head<br>☐ Neck<br>☐ Back_____<br>☐ Arms/shoulders<br>☐ Hips<br>☐ Legs/knees<br>☐ Other<br>What is your general health status?<br>_____<br>Do you have any metal in your body?<br>☐ Pins/wires<br>☐ Artificial joints<br>☐ Special equipment<br>_____ |

Health History : Indicate conditions you have experienced or currently experiencing:

Current
Medications:_____
Surgery_____
Date_____
Injury _____
Date_____
Do you exercise regularly? (i.e. 3 times per week) If so, specify_____
Have you or are you currently receiving other treatment? i.e.physiotherapy,chiropractic,naturopathic
_____
Please state any other health conditions that may be relevant and should be included here:
_____
To ensure your safety before receiving massage therapy, it is important to give an accurate health history. If your history changes in the future, please notify your therapist as soon as possible. All of your information gathered is completely confidential and will not be released except when required by law or to fascilitate assessment or treatment, which will only be released with your written consent.

I hereby request and consent to the service of massage therapy treatment and other massage procedures, including various modalities of matrix repatterning, remedial exercise and hydrotherapy, on me by the registered massage therapist.

Patient Signature (Legal Guardian)_____ Date_____

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PATIENT INFORMATION

Last name: _____ First Name: _____

Date of Birth: Month _____ Day _____ Year _____

Address: _____

City/Province: _____

Postal Code: _____

Home Phone: _____ Other Phone: _____

Email Address: _____

Guardian Name (if under age 18): _____

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Family Physician: _____ Phone #: _____

Physician Address: _____

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EMERGENCY CONTACT INFORMATION:

Name: _____ Phone #: _____

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REFERRAL INFORMATION

Referring Source (eg: Physician, friend, internet): _____

Reason Why you selected Matrix Massage: _____

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EXTENDED INSURANCE COVERAGE (Optional)

Insurance Co. Name: Coverage Amount:_____

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EMPLOYER INFORMATION

Employer Name: _____ Phone: _____

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TERMS AND CONDITIONS

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY FAMILY, REFERRING PHYSICIAN AND/OR INSURANCE COMPANY/REHABILITATION OFFICERS.

PAYMENT IS DUE UPON COMPLETION OF APPOINTMENT/SERVICE VIA CASH, VISA, MASTERCARD OR DEBIT.

PLEASE PROVIDE 24 HOURS NOTICE FOR APPOINTMENT CHANGES OR CANCELLATIONS. A FEE MAY BE CHARGED FOR MISSED APPOINTMENTS WITHOUT APPROPRIATE CANCELLATION. APPOINTMENTS CAN BE MANAGED ON-LINE VIA THE MATRIX MASSAGE WEBSITE.
*PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS.

SIGNATURE: _____ DATE: _____