Elsie Dyck RMT, CMRP

113 Queens Ave, Leamington, On., N8H 3H3
TEL: 519-326-6247
www.elsiedyck.com
www.matrixforpractitioners.com

It is my hope that I can assist you with your current and future health concerns. At any time, please feel free to comment, ask questions, and provide feedback. The more you understand and know about yourself, the more effective your treatments will be. I look forward to helping you achieve greater health and well-being

Please remember to wear stretchy, comfy clothes to your appointment, e.g. jogging pants; t-shirt; leggings. For women, a bra that DOES NOT have wire.

The following patient information is required and kept confidential unless required by law or with your signed permission

First Name: _____ **Last Name:** _____
Street Address1: _____
Street Address2: _____
City: _____ **Prov/State:** _____ **Postal Code:** _____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____

Email: _____

Age: _____ **Birthday:** _____
Month Day Year

Male Female

Occupation: _____

Place of birth: _____

If the patient is a child please give the parents' names:
Mother: **Father:**
Note: for patients 12 and under please use the children's health questionnaire

Medical Doctor: _____ **Telephone:** _____
Doctor Address: _____

How did you hear about Matrix Repatterning? : _____

Your reason for seeking care by Matrix Repatterning?:	Length of time or Since?

Activities or positions that aggravate your symptoms:

How do you try to find relief?

Have you received other forms of therapy for this condition? Current____ Previous___
Please specify:

****Remember that even if an "accident" happened many years before, this injury is still relevant to your care, please take your time to include all****

Motor Vehicle Collision: # of incidences _____

DATE	Seatbelt? y/n	Position in vehicle	Side/Direction of Impact?	Whiplash?	Sore? y/n

Work Related Injury: What happened?

Date	

Number of children: # of Natural births _____ # of C-sections_____

Surgeries including dates; also including any dental surgeries or fillings, root canals, jaw reconstruction etc,. I

Date	Surgery

Fractures/ Sprains:

Date	Incident

Other Injuries including Falls and Impacts. Gymnastics?, figure skating?, hockey? …etc,.

Date	

Major illnesses:

Date	Illness

How is your general health? How well does your body heal?:

Exercise (type and times per week):

Do you feel you are under excessive stress? Yes No
What are the things that you find stressful?

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

Current Medications or Supplements:

What are your goals for treatment?:

Have you ever in your life had an issue with…? Please check all that apply.

C = Current P = Previously 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 Heart Beat
				Pacemaker
				Poor Circulation
				Stroke

C	P	O	N	**Skin**
				Bruise Easy
				Bleed Easy
				Dryness
				Eczema
				Itching
				Psoriasis
				Rashes
				Sensitivites
				Varicose Veins

C	P	O	N	**Infections**
				AIDS
				Hepatitis
				Herpes
				HIV
				Infectious Skin Conditions
				Tuberculosis

C	P	O	N	**Eye, Ear, 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	**HEAD**
				concussion/diagnosed or not
				Whiplash

C	P	O	N	**Women**
				Backache
				Bladder Dysfunction
				Caesarian Section
				Cramps
				Fibroids
				Mid Cycle Pain
				Ovarian Cysts
				Painful Menstruation
				Pregnancy *

*If currently Pregnant,

Due Date_____

C	P	O	N	**General**
				Alcohol/Drug Problems
				Allergies
				Arthritis
				Blood in Urine
				Cancer
				Constipation
				Convulsions/Seizures
				Diabetes
				Esophageal Reflux
				Disgestive Problems
				Dizziness
				Fainting
				Fatigue
				Fibromyalgia
				Gall Bladder Poblems
				Kidney Problems
				Liver Problems
				Headache
				Hernia
				Insomnia/sleep Problems
				Mental Disorders
				Nervousness/Depression/Anxiety
				Neuralgia
				Osteoporosis
				Spinal Curvature

C	P	O	N	**Respiratory**
				Apnea
				Asthma
				Chronic Cough
				Difficult Breathing
				Snoring

ANYTHING ELSE?

Please bring this form with you to your appointment. The following must be read and your signature required before treatment can begin: If there is any information you do not know yet, wait for your appointment to ask then sign. Thank you :)

I am aware (Below) and understand the fee schedule and hereby agree to pay for services at the conclusion of each and every visit or make sure that payment is taken care of by benefits. Some special circumstances may occur.

*** I understand cancellations without 24 hr notice will result in a $30 fee. Less than 12 hrs cancelled or missed appointment will result in a fee of the full price of appointment. No charge for rescheduling. I also charge 20% above normal price for setting up appointments outside of normal working hours.**

You are always clothed during treatments. I treat your full skeleton, and fluid filled organs and other dense tissues. I need your permission to treat sensitive areas. That includes rib cage around breast tissue, full hips including pelvic bone, and tailbone. *Please Initial here that you have read, and agree to treatment areas
X_____ You are always free to remove consent to treat.

***All your information is kept confidential unless required by law or given with your signed permission. By Signing you also give Elsie Dyck, RMT, CMRP permission to consult with your doctor in case of emergency.**

***Always feel free to ask questions or discuss your concerns with your practitioner. Your treatment is always based on the knowledge of the practitioner and the most safe and beneficial treatment they can give you and to that you give consent. By signing this page, you also agree to the treatment plan as set out by your practitioner. You are also free to discuss and change treatment plan as you need. Treatment goes best when you are well educated about the process of healing.**

*** You give permission to Elsie Dyck, RMT to only add information to this health history form that you have verbally stated during assessment that was not previously recorded by you on this form.**

_____ _____
Client Signature **Date**

_____ _____
Parent or Guardian Signature if client is under the age of 18 **Date**

Fee Schedule (Includes HST)

Initial Assessment and Treatment		**$113.00**
Subsequent visits are presumed 60 min		**$101.70**
Shorter visits:	**45m**	**$76.28**
	30m	**$50.85**
	15m	**$25.43**
Child 0-5yrs Initial/subsequent 30 min		**$25.43**
Laser Sessions of 3		**$50.85**
Missed Appointment Fee		**Upon Request**
After Hours Appointment		**Regular Fee+ 20%**

Payment by : Direct Billing for Massage Therapy, Visa, Mastercard, Debit, Cash, or Cheque