



Alexis Conway RMT
 The Roberts Centre of Integrative Medicine
 375 University Ave. E. Waterloo, Ontario
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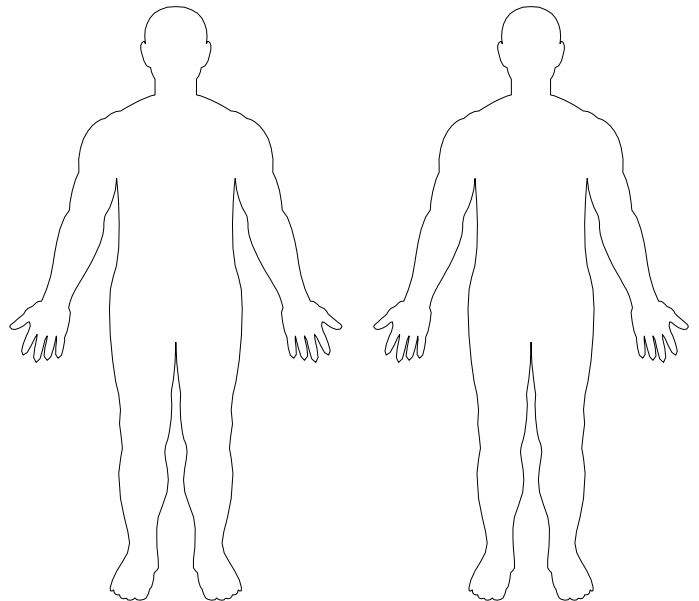
PATIENT ENTRANCE FORM

Name: _____ Patient Number: _____
 Date: _____
 Mailing Address: _____ Postal Code: _____
 Phone Number Residence: _____ Daytime Phone Number: _____
 Date of Birth/ Age: _____ Marital Status: S M D W S
 Occupation/ Employer: _____
 Medical Doctor: _____ Referred By: _____
 Previous RMT : _____
 Email address: _____ May we leave message or mailing Y N

Explain Your Current Complaint: _____

Kindly complete the Symptom Diagram below using the following symbols:

- Numbness ??????
- Burning ////////
- Pins & Needles
- Sharp & Stabbing XXXX
- Dull & Achy +++++
- Stiff & Tight 22222
- Weakness wwwww



Front

Back

Pain Scale: Place and "X" to correspond with your level of discomfort.

Day	0 _____ 10
Night	0 _____ 10
Sitting	0 _____ 10
Standing	0 _____ 10
Walking	0 _____ 10
Working	0 _____ 10
Sleeping	0 _____ 10



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General Questions:

1. Are you on any medication (including Aspirin, etc.)? Yes ___ No ___
 If yes, what type? _____

2. Have you had surgery? Yes ___ No ___
 If yes, what/when? _____

3. Do you have any pins, wires or artificial joints? Yes ___ No ___
 If yes, what/when? _____

4. Do you ever experience weakness, tingling, burning or loss of feeling anywhere?
 Yes ___ No ___ if yes, give location and frequency: _____

5. Describe any injuries that you have experienced in the past? (Sprains, broken bones, dislocations etc.) _____

6. Have you ever been in a motor vehicle accident? Yes ___ No ___
 If yes, describe any injuries you may have had. _____

7. Are you currently under the care of any other Health Professional(s)? _____

Comments: _____

This is necessary to enable us to give a more complete treatment and to help ensure your safety. All information received is kept in the strictest confidence. Thank you!

CONSENT TO TREATMENT:

All clients will be assessed and given a proposed treatment plan specific to their condition. Open communication between the therapist and the client is welcomed and encouraged at any time regarding all aspects of the client's treatment. No part of the client's body will be uncovered at any time except for the area being treated. If this is not acceptable, alternatives will be discussed. If the client becomes uncomfortable or has any questions during the session, they may stop or adjust the treatment at any time they wish.

I have fully read and understood all of the above information and give my consent to be treated by Alexis Conway, RMT

Signature _____ Date _____



SYMPTOMS: PAST AND PRESENT

Please **circle** any condition or symptom that you are presently experiencing.

Please **check off** those conditions or symptoms that you have experienced in the past.

GENERAL SYMPTOMS

- Loss of consciousness
- Blackouts
- Headaches
- Fever
- Sweats
- Fainting/ dizziness
- Clumsiness
- Slurred speech
- Convulsions
- Loss of sleep
- Night pains
- Nervousness/ anxiety
- Paralysis
- Numbness, pain, or tingling
- Loss/ increase of weight

MUSCLES AND JOINTS

- Neck pain
- Mid-back pain
- Low back pain
- Painful tail bone
- Shoulder pain
- Elbow pain
- Wrist pain
- Hand pain
- Hip pain
- Knee pain
- Ankle pain
- Foot pain
- Weakness/ loss of strength
- Arthritis
- Degenerative disc disease
- Tendonitis/ bursitis
- Jaw/ TMJ pain
- Cortisone injections
- Gout

- E.E.N.T.
- Eye pain
- Double/ blurred vision
- Seeing black spots/ stars
- Failing vision
- Earache
- Deafness/ gradual hearing loss
- Ringing/ buzzing in ears
- Frequent colds
- Sinus infection
- Asthma
- Enlarged glands/ nodes
- Enlarged thyroid
- Difficulty swallowing

RESPIRATORY

- Chronic cough
- Spitting up phlegm or blood
- Chest pain
- Difficulty breathing
- Shortness of breath

CARDIOVASCULAR

- Stroke
- Heart attack
- High/ low blood pressure
- Pacemaker
- Angina
- Bleeding disorder
- Varicose veins
- Swelling of ankles/ legs
- Poor circulation
- High cholesterol
- Congestive heart failure

GASTROINTESTINAL

- Poor appetite
- Belching/ gas
- Heartburn
- Ulcers
- Nausea/ vomiting (blood?)
- Pain over stomach
- Excessive hunger
- Gall bladder problems
- Liver problems
- Jaundice/ yellow skin colour
- Constipation
- Diarrhea
- Hemorrhoids

GENTIOURINARY

- Painful/ excessive urination
- Trouble initiating urination
- Abnormal urine colour/ smell
- Kidney problems/ infections
- Prostate problems
- Bladder problems/ infections
- Hernia
- Pain in genitals
- Lumps in genitals

SKIN

- Rashes/ itching/ dryness
- Hives
- Bruise easily
- Infections
- Changes in area/ border/ colour/ size of moles

FOR WOMEN

- Painful menstruation
- Irregular cycle
- Excessive flow
- Cramps
- Hot flashes
- Menopause
- Swollen breasts
- Lump(s) in breasts
- Endometriosis
- Abnormal vaginal discharge

Have you ever taken oral contraceptives? Yes/ no
 Are you currently taking oral contraceptives? Yes/ no
 Is there a chance you may be pregnant? Yes/ no

#pregnancies _____
 #children _____

GENERAL HISTORY

Have you had any fractures?
 Yes/ no

Have you ever had surgery or been hospitalized? Yes/ no

Have you ever been in a motor vehicle accident or had other major trauma? Yes/ no

Have you smoked tobacco in the past? Yes/ no
 #packs/ day/ years _____
 Currently smoke? Yes/ no

Do you take medication on a regular basis? Yes/ no

Do you suffer from allergies?
 Yes/ no

*****Please indicate if you have been diagnosed with any of the following:*****

Cancer, Diabetes, Hepatitis A/ B/ C, Tuberculosis, HIV/ AIDS.

Please notify the doctor if you have been diagnosed with a major systemic illness/ disease