Markham Family Chiropractic & Physiotherapy Clinic

The information contained herein is strictly confidential between patient and doctor.
Each question helps to build a complete picture of your health.
Please elaborate where necessary.

Date: _____________

Name: ____________________ Address:____________________________ Birth Date: _____________
Postal Code: _____________ Occupation: __________________ Home Phone:______________________
Bus. Phone:__________________ Email:_________________________ Cell Phone: _______________
Marital Status: ________ # of Children: _____________ How were you referred to our office: _________
What is your main complaint?____
How long have you had this complaint for?____
Does this condition interfere with: Sleeping Working / Daily Activities Exercise
Previous hospitalization(s) or Surgery(s):____
Have you had previous chiropractic care?____ By Whom & Date:_______________________________
* Medical Doctor: ___________________ Tel:_________________ Address:________________________

Do you have or did you ever have:

0 Allergies
0 High/Low Blood Pressure
0 Dermatitis
0 Prolonged Bleeding
0 Heart Disease
0 Lung Disease
0 Kidney Disease
0 Liver Disease
0 Diabetes
0 Cancer
0 Hepatitis
0 AIDS
0 Thyroid Disease
0 Venereal Disease
0 Seizures
Other:__________________

Family Medical History:

0 Allergies
0 High/Low Blood Pressure
0 Dermatitis
0 Prolonged Bleeding
0 Heart Disease
0 Lung Disease
0 Kidney Disease
0 Liver Disease
0 Diabetes
0 Cancer
0 Thyroid Disease
0 Migraines
0 Seizures

Are you taking Prescription Medications? Please list:

____
____
____
____
____
____

Are you taking any:
0 Supplements
0 Vitamins
0 Herbs
0 Antacids

Please list:
____
____
____

Lifestyle
Please check all that apply:

0 alcohol # of drinks (e.g. wine, spirits, beer) per week: __________
0 caffeine # of drinks (e.g. coffee, tea) per day: ________________
0 smoking # of cigarettes per day: ____________________________
0 recreational drugs: ____
0 exercise # of hours per week: ___________________ Type of Exercise: ________________

Musculoskeletal

Please check any complaints you currently have and indicate the severity:

Symptom	mild	moderate	severe	**Symptom**	mild	moderate	severe
0 Neck Pain				0 Arm Pain			
0 Neck Stiffness				0 Wrist Pain			
0 Headaches				0 Elbow Pain			
0 Migraines				0 Finger Pain			
0 Shoulder Pain				0 Thigh Pain			
0 Pain Between Shoulders				0 Hip Pain			
0 Tingling in Extremities				0 Toe Pain			
0 Mid Back Pain				0 Knee Pain			
0 Low Back Pain				0 Ankle Pain			
0 Numbness				0 Heel Pain			

0 Other: ____

Systemic

Please check any complaints you currently have and indicate the severity:

Symptom	mild	moderate	severe	**Symptom**	mild	moderate	severe
0 diarrhea				0 tinnitus			
0 constipation				0 shortness of breath			
0 abdominal discomfort				0 asthma			
0 poor appetite				0 dizziness			
0 fatigue				0 difficulty concentrating			
0 vision problems				0 stress			
0 vision loss				0 depression			
0 hearing loss				0 insomnia			

Other: ____

Symptom Diagram

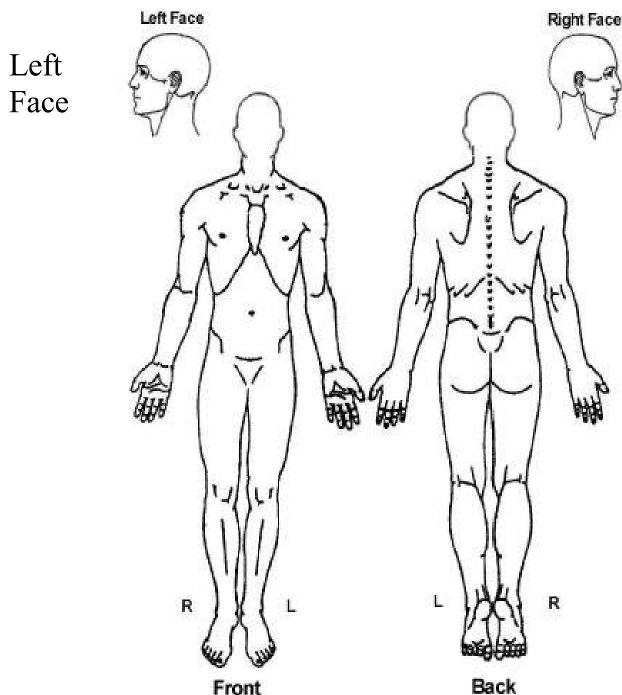
In the diagrams provided below, please mark the areas on your body which you feel best represent the pain or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below:

Symbols:

Numbness: ________ ________ **Pins & Needles:** :::::::::::: **Burning:** xxxxxx

Stabbing & Sharp: oooooooo **Dull & Achy:** +++++++ **Stiff & Tight:** 222222

Left Face



Right Face

Please rate your level of pain along the line, with "None" being no pain at all, and "Max" being the worst pain you have ever felt.

I______________I______________I
None   Max

Back

Patient Signature:___________________ Date:_________