

Markham Family Chiropractic 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: _____

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: Family Medical History:

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

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

Are you taking Prescription Medications? Please list:

- _____
- _____
- _____
- _____
- _____

Are you taking any:

- Supplements
- Vitamins
- Herbs
- Antacids

Please list:

- _____
- _____
- _____

Lifestyle

Please check all that apply:

- alcohol # of drinks (eg. wine, spirits, beer) per week: _____
- caffeine # of drinks (e.g. coffee, tea) per day: _____
- smoking # of cigarettes per day: _____
- recreational drugs: _____
- 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
<input type="checkbox"/> Neck Pain				<input type="checkbox"/> Arm Pain			
<input type="checkbox"/> Neck Stiffness				<input type="checkbox"/> Wrist Pain			
<input type="checkbox"/> Headaches				<input type="checkbox"/> Elbow Pain			
<input type="checkbox"/> Migraines				<input type="checkbox"/> Finger Pain			
<input type="checkbox"/> Shoulder Pain				<input type="checkbox"/> Thigh Pain			
<input type="checkbox"/> Pain Between Shoulders				<input type="checkbox"/> Hip Pain			
<input type="checkbox"/> Tingling in Extremities				<input type="checkbox"/> Toe Pain			
<input type="checkbox"/> Mid Back Pain				<input type="checkbox"/> Knee Pain			
<input type="checkbox"/> Low Back Pain				<input type="checkbox"/> Ankle Pain			
<input type="checkbox"/> Numbness				<input type="checkbox"/> Heel Pain			
<input type="checkbox"/> Other: _____							

Systemic

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

Symptom	mild	moderate	severe	Symptom	mild	moderate	severe
<input type="checkbox"/> diarrhea				<input type="checkbox"/> tinnitus			
<input type="checkbox"/> constipation				<input type="checkbox"/> shortness of breath			
<input type="checkbox"/> abdominal discomfort				<input type="checkbox"/> asthma			
<input type="checkbox"/> poor appetite				<input type="checkbox"/> dizziness			
<input type="checkbox"/> fatigue				<input type="checkbox"/> difficulty concentrating			
<input type="checkbox"/> vision problems				<input type="checkbox"/> stress			
<input type="checkbox"/> vision loss				<input type="checkbox"/> depression			
<input type="checkbox"/> hearing loss				<input type="checkbox"/> 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:

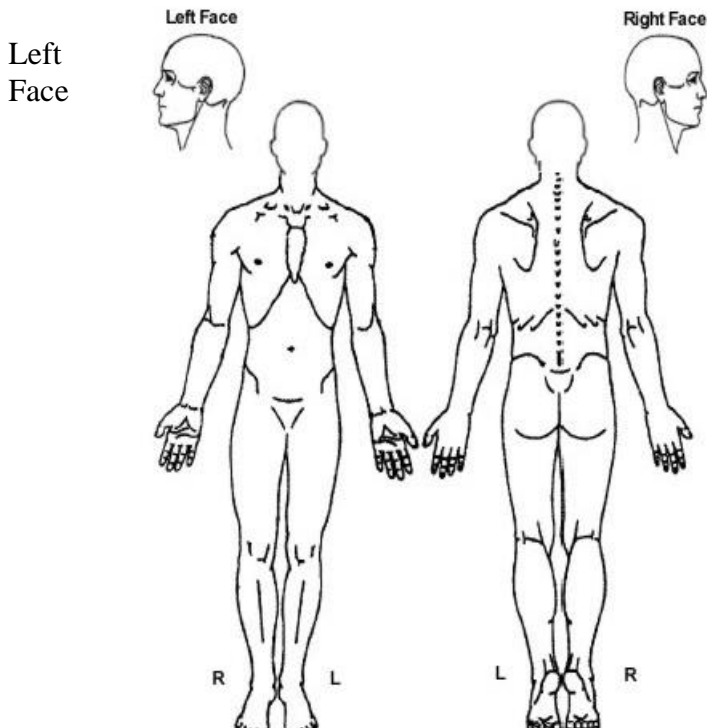
Symbols:

Numbness: _____ Pins & Needles: ::::::::::: Burning: xxxxxx

Stabbing & Sharp: oooooooooo

Dull & Achy: +++++++

Stiff & Tight: 222222



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: _____