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

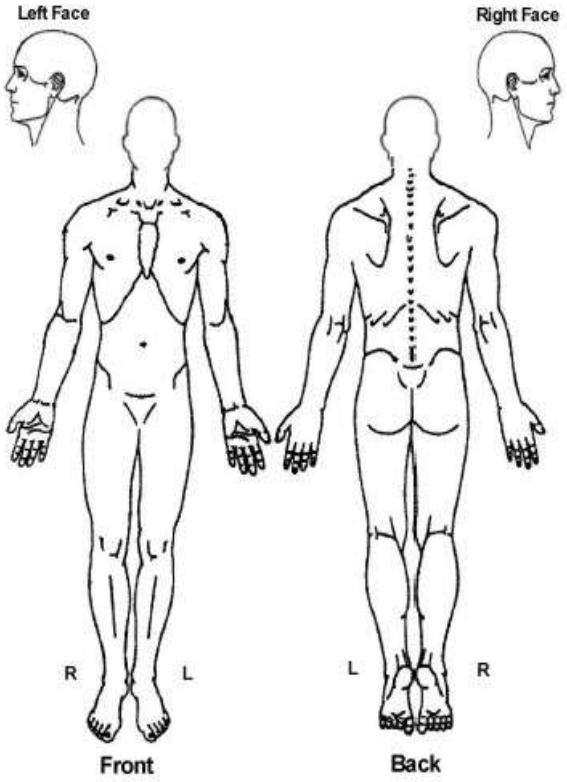
In the diagrams provided below, please mark the areas on your body which you feel best represent the pain or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below:

Symbols:

Numbness:

Pins & Needles: :::::::::::: **Burning: xxxxxx**

ull & 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

Musculoskeletal

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

Patient Signature:_____ Date:_____