Markham Town Square Health Centre
8601 Warden Ave., Unit 23 (at Hwy 7) Markham, ON L3R 2L6
Tel: 905-940-9988 Ext. 4 Email: mtschiropractic@gmail.com
www.markhamchiro.com

Patient Introduction

Personal History:

Your Name:
____

Your Address:
____

____
City Province Postal Code

Telephone: Res: ______________________Bus./Cell:________________________

Birth Date: Day: _______ Month: _______Year: _______ Gender: F/M

Email Address:____

Marital Status: _______ Occupation_______________________

Employer:_________________________

Present MD: ____________________________ City: _______________________

Telephone: ______________________ Date of last physical: ___________________

Previous Chiropractor: ____________________________City:_________________

Last visit to this Chiropractor:__________ Reason for leaving: __________________

Referred to our Centre by: (please circle and/or write)

1. Walk-In
2. Internet/Web
3. Yellow Pages
4. Advertising
5. Patient _________________
6. Physician _______________
7. Other Health Care Provider
8. Other__________________

Adult Consultation History

***If any of the following questions do not apply to you, please mark as N/A**

Current health complaint(s):____

Any other complaints:____

When did this begin?____

Has the condition occurred before? Yes No When?___________________________

What have you tried to get rid of this problem that DID NOT work?

____

Describe how your problem began:

____

What does it feel like? Sharp Dull Ache Pins & Needles Numb Burning Other: ________

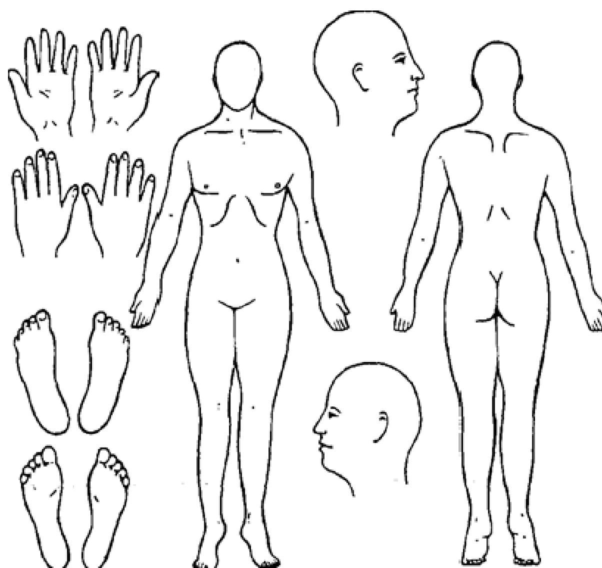
How does this problem interfere with the following areas of your life?
WORK: ____
FAMILY: ____
HOBBIES: ____
LIFE____
Frequency of Pain (circle): Constant Frequent Occasional Comes and goes

Is this condition: Job Related Car Accident Fall Sports Injury Other: ______________

Please circle a number below to indicate your current level of pain

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Please circle sites of pain and other symptoms in the diagram below



Has the problem been getting (circle): Worse Better Stayed the Same

What makes the problem worse?

____

What makes the problem better?

____

Is your problem affecting any of the following? (circle) Work Exercise Daily Activities

Have you had any previous injuries to the problem area? No Yes

If Yes, When? _______________________

Have you seen another health professional for this problem? No Yes

If Yes, Whom? _______________________

On a scale of 1-10 with 10 being the highest, rate your commitment in helping us solve this problem: ________

Health History

Do you have any medical conditions that you are aware of?

No Yes _____________________________________

Please list any medications or supplements you are currently taking:

____

Any Recent Surgeries:

____

Occupation________________________________ Full time__ Part time__

Physical activity at work: __sitting more than 50% of workday __Light manual labour

__heavy manual labour __repetitive movements

Has your work status been affected by your complaint?

____

If a family member has had any of the following please circle:

Epilepsy
Chronic Back Problems
Chronic Headaches
Lupus
Cancer
Rheumatoid Arthritis
Diabetes
Heart Problems
Lung Problems
High Blood Pressure

Please circle any of the following that applies to you:

Pregnant
Birth Control Pill
Hormone/Estrogen replacement
Medications
Tobacco Dependence
Alcohol Dependence
Drug Dependence

Please check the column to indicate conditions that you are presently troubled by or have been troubled by in the past. The information you provide concerning your past and present conditions helps your doctor more thoroughly understand your overall health status.

Condition	**Past**	**Present**	**Condition**	**Past**	**Present**
Hepatitis			Aortic Aneurysm		
Heart Attack			Cancer		
Breast Soreness/Lumps			Epilepsy		
Chest Pain/Angina			HIV/AIDS		
Chronic Cough			Irritable bowel/Constipation		
Emphysema			Kidney stones		
Difficulty Swallowing			Liver/Gallbladder problems		
Dizziness			Ulcer		
Blurred Vision			Rapid heart beat		
Fainting			Prostate problems		
Endometriosis			Ringing in the ears		
General Fatigue			Shoulder pain		
Headache			Rheumatoid Arthritis		
Heartburn/Indigestion			Upper Back Pain		
Abnormal Weight Loss			Visual Disturbances		
Night Sweats			Wrist Pain		
Night Pain			Asthma		
Systemic Lupus			Bladder Infection		
Irregular Menstrual Flow			Arthritis		
Excessive Thirst			High Blood Pressure		
Frequent Urination			Diabetes		
Pain in Arm/Elbow/Hand /Wrist			Stroke		
Jaw Pain			Colitis		
Loss of Bladder Control			Lower limb pain		
Low Back Pain			Plantar Fasciitis		
Muscular Incoordination			Painful Urination		
Neck Pain			Kidney Stones		
Osteoporosis/Osteopenia			Varicose Veins/Swollen feet or ankles		