Markham Family Physiotherapy
& Chiropractic Clinic

Health History Form

Name:		**Date:**
Address:		**Telephone (Cell):**
Postal Code:		**(House)**:
Email:		
Birthday:	**Height:**	**Weight:**
What brings you in?		
Referred by:		

Please circle the conditions that you are (**C**) currently experiencing or have (**P**) previously experienced.

Head/Neck

- **c p** Headaches
  Type:_____
- **c p** Vision Problems
- **c p** Contact Lenses
- **c p** Glasses
- **c p** Ear Infections/ Aches

Respiratory

- **c p** Chronic Cough
- **c p** Shortness of Breath
- **c p** Smoking
- **c p** Breathing Problems
  Type:_____

Women

Pregnant
Due Date:_____

Cardiovascular

- **c p** High Blood Pressure
- **c p** Low Blood Pressure
- **c p** Poor Circulation
- **c p** Heart Disease
- **c p** Stroke
- **c p** Phlebitis
- **c p** Varicose Veins

Skin

- **c p** Psoriasis
- **c p** Eczema
- **c p** Bruise easily

Other Conditions

- **c p** Difficult Digestion
- **c p** Constipation
- **c p** Liver
  Gall
- **c p** Bladder
- **c p** Kidneys
- **c p** Stomach
- **c p** Diabetes
  Type:_____
- **c p** Sinus
- **c p** Allergies_____
- **c p** Insomnia
- **c p** Cancer_____
- **c p** Arthritis_____

General Health Status

Other Medical Conditions

Surgery

Type:
Date:
Symptoms:

Injury

Type:
Date:
Symptoms:

Medical Doctor

Name:
Address:
Phone Number:
Date of Last Visit:

Medications

Name: Condition:

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

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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:_____							

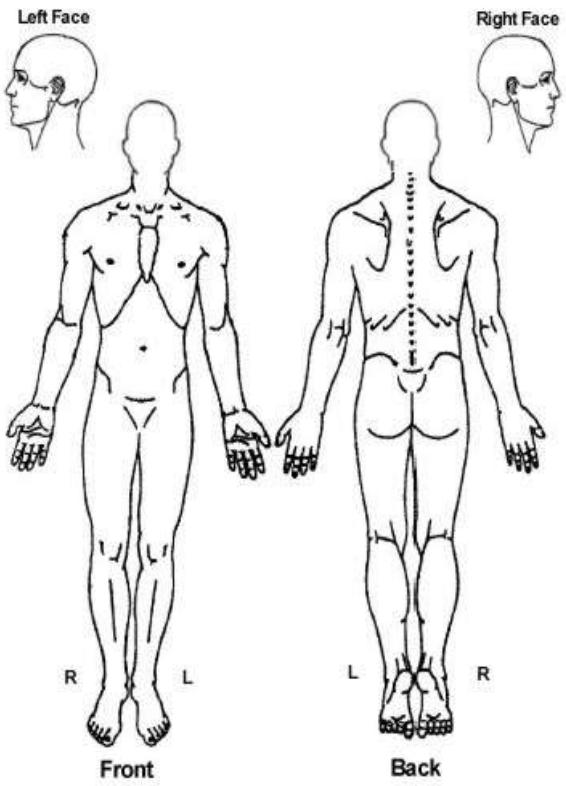
Symptom Diagram

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

Front

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

Patient Signature:_____ Date:_____