Dr. Marco Caravaggio
Family Chiropractor
3160 Steeles Ave. E., Suite 216
Markham, ON, L3R 4G9
Tel. 905-477-8900

Our mission is to help as many people as we can in our lifetime – especially children.

Patient Introduction

Date: ____________________ Gender: M F

Personal History:

Your Name: ____
First Middle Last

Your Address:
____
____
____

Telephone: Home:__________________________ Bus: ____________________

Cell: ___________________________

Email Address: ____
(By giving us your email address, you give the office permission to send you important clinic updates via email. You may ask to be taken off our clinic mailing list at any time)

Birth Date: Day: _____________ Month: ________________ Year: ____________

Occupation: ______________________Employer: ________________________

Previous Chiropractor: ______________________________ City: _______________

Last visit to this Chiropractor:______________________

Reason for leaving:
____
____

Present MD: ______________________________________ City: _______________

Marital Status:_____________________Spouse Name: ________________________

Children: Y ___ N___ Names & Ages: _____________________________________

Emergency Contact: ________________________ Phone No. __________________

Relationship to Emergency Contact: _____________________________________

Referred to our Center by:____

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Adult Consultation History

Your Name:____ Gender M F

Your Main Complaint:____

Any other Complaints: ____

____

How long have you suffered with this problem? _ ________________________________

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

____

____

Have you become discouraged about handling this problem? ________________________

When your problem is at its worst, how does it make you feel? ________________________

____

How does this problem interfere with the following areas of your life?

WORK: ________________________________

FAMILY:

HOBBIES: ________________________________

LIFE: ________________________________

Does handling this problem cause stress for you? ________________________________

____

What do you do that makes this problem worse? ________________________________

____

How much older does this make you feel: ________________________________

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

What gives you some temporary relief? ________________________________

____

What is the pattern of this problem? Constant ____ Intermittent ____ Occasional ____ Cyclic ____

What is the effect it has on your body functions? ________________________________

____

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How did it start? ____

Are you on any type of medication?__________ Please list all: ______________________
____
____

Could your problem have been caused by an injury at work?______________________

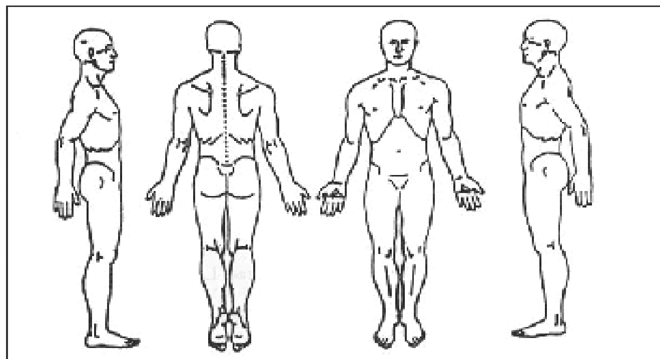
If yes, please give us the details: ________________________________
____
____

Have you been involved in an auto accident? ______________________________

Date of accident: ___________

Any difficulties from this?____

Using the adjacent body charts, please circle ALL affected areas. →



Have you ever been treated by a medical physician for this pain? Yes No If so, where?
____

Have you had <u>any</u> previous surgeries? ________________________________
____

Have you ever had any fractures or broken bones? Yes No Where\When:
____
____

Are you taking any of the following medications? Nerve Pills Pain killers (including aspirin)

High Blood Pressure Medication Cholesterol Medication Anxiety Medication

Muscle Relaxants Blood Thinners Tranquilizers Insulin

Other(s):____
____

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Please mark the following conditions you may have had or have now:

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ Hemophilia	☐ High Blood Pressure
☐ HIV (AIDS)	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Irregular Periods	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Is there anything else you would like the Doctor to know?

____

____

For Women Only

Date of your last menstrual period: ______________________________

Are using any means of contraception? __________________________________

Do you experience severe cramping with your menstrual period? ____

Do you suffer from PMS? _______________________________________

Are you pregnant? ___________ If so, how far along? ______________

SIGNATURE: _____________________________________ DATE: ________________________________

Thank You!