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

Patient Introduction

Date: _____ Gender: M F Other

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: _____

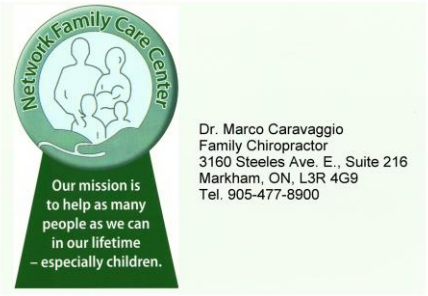
Marital Status:_____Spouse Name: _____

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 ___

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

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

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?_____

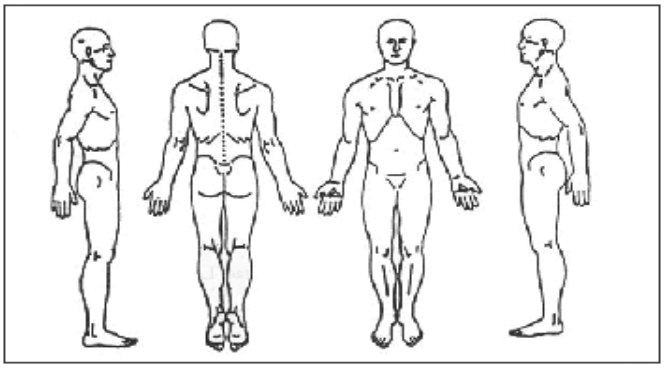
If yes, please give us the details: _____
_____
_____

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? _____
_____

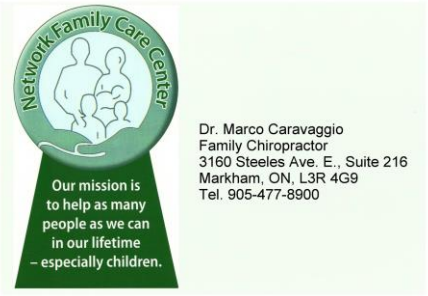
Have you ever had any fractures or broken bones? Yes No Where\When:
_____
_____

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: _____