Markham Chiropractic
Dr. Michael G. Robbins, D.C.
326 Main Street North
Markham, ON L3P 1Z1

OFFICE USE ONLY
Patient Number: _____
Diagnostic Code: _____

PATIENT ENTRANCE FORM

PATIENT INFORMATION

Last Name:		Middle Initial:		First Name:	
Preferred Name:					
Home Address:		City:		Postal Code:	
Age:		Birthdate:		Gender: ☐ M ☐ F	Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ O
Would you like to receive our email newsletter? ☐ Y		Email Address:			

PATIENT CONTACT INFORMATION

Patient Home #:		Patient Work #:		Patient Cell #:	
Emergency Contact Name:				Relationship:	
Home Phone:		Work Phone:		Cell Phone:	
Family Doctor:				Phone:	

PATIENT EMPLOYER / SCHOOL INFORMATION

Please check one: ☐ Employed ☐ Retired ☐ Student ☐ Other:					
Address:		City:		Postal Code:	
Phone:		Occupation:			

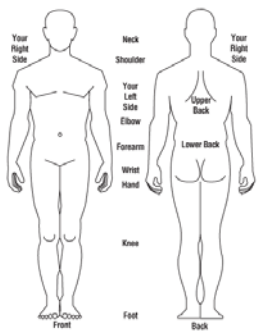
REFERRAL INFORMATION

How did you hear about our office? (please check one of the following)

☐ Yellow Pages ☐ Newspaper ☐ Sign ☐ Website ☐ Web Search ☐ Other:

Referred by: ☐ Doctor ☐ Patient ☐ Family Member Name:

PATIENT CONDITION

Reason for Visit:	Mark an X to identify pain location:
When did symptoms appear?	
Is condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown	
Rate the severity of your pain from 1 (least) to 10 (severe)	
Type of Pain: ☐ Sharp ☐ Burning ☐ Aching ☐ Dull ☐ Tingling ☐ Swelling ☐ Throbbing ☐ Cramps ☐ Shooting ☐ Numbness ☐ Stiffness ☐ Other	
How often do you have this pain?	
Is it constant or does it come & go?	

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY [redacted]

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other

Name and address of Doctor(s) who have treated your condition:

Are you pregnant?		☐ Yes ☐ No	Due Date:			
Date of Last:	Physical Exam		Spinal X-ray		Blood Test	
	Spinal Exam		Chest X-ray		Urine Test	
	MRI/CT Scan		Bone Mineral Density Test			

Please check the appropriate box if you have had any of the following:

☐ AIDS/HIV	☐ Chicken Pox	☐ Kidney Disease	☐ Prosthesis
☐ Alcoholism	☐ Diabetes	☐ Liver Disease	☐ Psychiatric Care
☐ Allergy Shots	☐ Emphysema	☐ Measles	☐ Rheumatoid Arthritis
☐ Anemia	☐ Epilepsy	☐ Migraine Headaches	☐ Rheumatic Fever
☐ Anorexia	☐ Fractures	☐ Miscarriage	☐ Scarlet Fever
☐ Appendicitis	☐ Glaucoma	☐ Mononucleosis	☐ Stroke
☐ Arthritis	☐ Goiter	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Asthma	☐ Gonorrhea	☐ Mumps	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gout	☐ Osteoporosis	☐ Tonsillitis
☐ Breast Lump	☐ Heart Disease	☐ Pacemaker	☐ Tumors/Growths
☐ Bronchitis	☐ Hepatitis	☐ Parkinson's Disease	☐ Ulcers
☐ Bulimia	☐ Hernia	☐ Pinched Nerve	☐ Vaginal Infections
☐ Cancer	☐ Herniated Disc	☐ Pneumonia	☐ STD
☐ Cataracts	☐ Herpes	☐ Polio	☐ Whooping Cough
☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problem	☐ Other

ACCIDENT [redacted]

Is condition due to an accident?	☐ Yes ☐ No	Date:	
Type of accident:	☐ Auto ☐ Work ☐ Home ☐ Other		
Accident Reported to:	☐ Auto Insurance ☐ Employer ☐ Workers Comp ☐ Other		
Attorney Name (if applicable):			

WORK ACTIVITY [redacted]

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS [redacted]

☐ Smoking Packs/Day:		☐ Alcohol Drinks/Week:		☐ Coffee/Caffeine Drinks Cups/Day:	
☐ High Stress Level	Reason:				

INJURIES/SURGERIES [redacted]

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS [redacted] ALLERGIES [redacted] VITAMINS/HERBS/SUPPLEMENTS

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature:		Date:		☐ Patient ☐ Parent ☐ Spouse