



Forest City Family Chiropractic

**440 Boler Rd. Suite 101
London, ON N6K 4L2
Phone: (519) 474-6808**

The purpose of our office is to restore and maintain the health of our patients through natural chiropractic methods.

Please complete this confidential health questionnaire fully and accurately.

The more Dr. Batte knows about the overall picture of your health, the better we will be able to help you. Doctors of Chiropractic are trained to detect and correct vertebral subluxations.

If you have any questions, do not hesitate to ask one of our staff for assistance.

Patient Information

Name: _____

Address: _____

City: _____ Prov: _____ Postal: _____

Telephone:

Home: _____ Cell: _____

Work: _____ Ext: _____

Email: _____

Heath Card: _____

Version Code: _____ Expiry: _____

Birthdate: _____ (day/month/year)

Gender: M F Height: _____ Weight: _____

Marital Status:

Single Married Divorced

Widowed Common-law

Name of Spouse: _____

Number of Children: _____

My Occupation: _____

Goals for My Care.

Experience With Chiropractic Care

Who referred you to our office? _____

Have you ever been adjusted by another Chiropractor?

Yes No

Reason for your previous care?

Were x-rays taken? Yes No

Were scans done? Yes No

Did your family receive chiropractic care?

Yes No

Chiropractor's name: _____

Approximate date of last visit: _____

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for the correction of whatever is malfunctioning in their bodies.

Your doctor will weigh your needs and desires when making recommendations for care. Please check the type of care desired so that we may be guided by your wishes whenever possible:

Relief Care - symptomatic relief of pain or discomfort

Corrective Care - correcting and relieving the cause of the problem as well as the symptoms.

Comprehensive Care - bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic

I would like the doctor to select the type of care appropriate to my health status.

What is the Purpose of this Appointment?

Describe the purpose of this visit: _____

Is the purpose of this visit related to:

Work Stress Sports Auto Fall Chronic Discomfort Repetitive Trauma Check-up Other

Please

explain: _____

(For a specific complaint, please complete the section below)

How long have you had this condition? _____

Have you had this or similar conditions before? _____

What aggravates your condition? _____

Has this condition become worse remains constant comes and goes

Does this condition interfere with Work Sleep Daily Routine Family Life Sports Other Activities

Have you seen any other health care providers for diagnosis or management of this condition?

Yes No

Practitioner's Name: _____ Practitioner's Name: _____

Type of Care: _____ Type of Care: _____

Date: _____ Results: _____

Date: _____ Results: _____

Results: _____

My Health Conditions

Please check each condition that you have now or have had in the past. While some conditions may seem unrelated to the purpose of your visit, they can affect diagnosis, care plan, and the possibility of being accepted as a patient.

General

- Allergy
- Convulsions
- Dizziness

- Fatigue
- Headache
- Loss of Sleep
- Loss of Weight
- Anxiety/Depression
- Numbness
- Cancer
- Diabetes
- Thyroid Problems
- Epilepsy
- Hyperactivity

Muscle & Joint

- Arthritis
- Hernia
- Low Back Pain

Numbness or Pain in:

- Shoulders
- Upper Arms
- Hands

- Legs
- Feet

- Poor Posture
- Swollen Joints
- Gout
- Polio

Gastro-Intestinal

- Constipation
- Diarrhea
- Digestive Dysfunction
- Gall Bladder
- Haemorrhoids
- Liver Problems
- Ulcers

Eyes, Ears, Nose, Throat

- Asthma
- Frequent Colds
- Crossed Eyes

- Deafness
- Ear Infections
- Ringing in Ears
- Eye Pain
- Vision Problems
- Nasal Obstruction
- Sinus Infection

Cardio-Vascular

- High Blood Pressure
- Low Blood Pressure
- Poor Circulation
- Irregular Heart Beat
- Ankle Swelling
- Anaemia
- Arteriosclerosis

Respiratory

- Chest Pain
- Chronic Cough
- Irregular Breathing
- Wheezing
- Emphysema

Genito-Urinary

- Bed Wetting
- Painful Urination
- Prostate Problems
- Blood in Urine
- Venereal Disease

Women Only

- Cramps
- Excess Menstruation
- Irregular Cycle
- Hot Flashes

Are you pregnant:

- Yes No

Other: _____

Potential Sources of Spinal Stress

To help us determine the cause of your problem, please indicate any potential sources of spinal trauma. (next page)

Potential Sources of Spinal Stress (continued)

General Physical Trauma

Falls (Details & Dates)

- As a child _____
- Down stairs _____
- On ice _____
- Sports impact _____
- Physical fight _____
- Other _____

Primary Daily Activities

- Sitting Standing Walking Desk Work
- Driving Manual Repetitive work Lifting

Exercise

- Heavy/Daily Daily Periodic

Describe _____

Sports and Leisure

Were you, or are you active in sports? Yes No

Describe _____

Have you been hurt in any of these activities?

- Yes No Details _____

Birth

With respect to your own birth process, check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Natural | <input type="checkbox"/> Epidural/drug induced |
| <input type="checkbox"/> Premature | <input type="checkbox"/> C-section |
| <input type="checkbox"/> Breech | <input type="checkbox"/> Chord around neck |
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Prolonged delivery |
| <input type="checkbox"/> Vacuum Extraction | <input type="checkbox"/> Pulling/twisting by doctor |

Did your mother sustain any falls, accidents or injuries during her pregnancy?
Yes No Unknown

Auto Accidents

Have you ever, even as a passenger been involved in a car accident or collision?

- Yes No (including if you do not think you were hurt)

If yes, please indicate the approximate dates and severity below:

If your chief complaint is not a direct response to a motor vehicle accident, please notify our staff, as we will require a separate questionnaire.

With respect to the questions below, please provide details where applicable, including dates:

Have you ever been knocked unconscious? Yes No

Have you ever used crutches, a walker or a cane? Yes No

Have you ever had any broken bones? Yes No

Have you ever had any impacts, falls or jolts that you feel specifically may have injured your spine?

- Yes No

Have you had extensive dental or orthodontic work performed? Yes No _____

Sprains, strains, dislocations: _____

Surgical operations and years: _____

Have you ever been hospitalized for other reasons? Yes No _____

Family Health History

Family Members with diagnosed health problems (eg Father - Arthritis) _____

History of Chemical and Personal Stress Health Habits

Medications I am presently taking

Painkillers _____

Anti-inflammatories _____

Muscle Relaxants _____

Blood Pressure Meds _____

Stimulants, Anti-depressants _____

Tranquilizers, Anti-anxiety _____

Blood Thinners _____

Birth Control _____

	Health Habits			
	Heavy	Moderate	Light	None
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Stress Levels				
Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I hereby authorize the doctors in this clinic to examine my condition and render care as deemed necessary.

In the event that X-rays are necessary in my case, I understand and agree that X-rays taken in this clinic are the property of Forest City Family Chiropractic and will remain in this clinic where they can be reviewed for me by the doctors.

I have listed below an emergency or alternate contact with whom this office may communicate. If I cannot be contacted personally or in the case of an emergency, this office has my consent to identify me as a patient to the contacts below.

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate care, any fees for professional services rendered will become immediately due and payable.

(Check if applicable) I have health insurance and/or accident insurance through _____

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself.

(Signature)(I have read and understand the above)

(Date)

Alternate Address

Permanent Temporary Parent Not Applicable

Name: _____
Address: _____ Unit # _____
City: _____ Pro _____
Postal _____ Telephone _____

Emergency Contact

Name of a relative or close friend not living at my address

Name: _____
Address: _____ Unit # _____
City: _____ Pro _____
Postal _____ Telephone _____