FOREST CITY FAMILY CHIROPRACTIC

"Structure Determines Function"

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.

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: __________________________

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

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 □Motor Vehicle Accident □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 (If yes, please complete the section below)

Practitioner's Name: ______________________
Type of Care: ____________________________
Date: ___________________________________
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
□Diarrhoea
□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
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.
□Natural
□Premature
□Breech
□Forceps
□Vacuum Extraction
□Epidural/drug induced
□C-section
□Chord around neck
□Prolonged delivery
□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 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 (Example: Father - Arthritis)

____

____

History of Chemical and Personal Stress

Medications I am presently taking:

- ☐Painkillers________________________________
- ☐Anti-inflammatory___________________________
- ☐Muscle Relaxants___________________________
- ☐Blood Pressure Meds_______________________
- ☐Stimulants, Antidepressants_________________
- ☐Tranquilizers, Anti-anxiety___________________
- ☐Blood Thinners_____________________________
- ☐Birth Control_______________________________

Health Habits

	Heavy	Moderate	Light	None
Tobacco	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Prescription Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Personal Stress Levels				
Past	☐	☐	☐	☐
Present	☐	☐	☐	☐

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 my 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

Family Physician Information

Name:_______________________________________
Address:_____________________________________
Unit#:_______________**City:**_____________________
Postal Code:____________**Phone:**________________

Emergency Contact Information

Name:_______________________________________
Address:_____________________________________
Unit#:_______________**City:**_____________________
Postal Code:____________**Phone:**________________