



Forest City Family Chiropractic

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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: _____

Health 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: _____

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

No _____

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

No _____

Sprains, strains, dislocations: _____

Surgical operations and years: _____

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

