

# **CORRECTIVE**

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# **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.

## **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: \_\_\_\_\_

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

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	<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"/>
<b>Personal Stress Levels</b>				
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 Corrective 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

## Family Physician Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Unit#: \_\_\_\_\_ City: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

## Emergency Contact Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Unit#: \_\_\_\_\_ City: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_