Priority Chiropractic
218 Bayfield St., Barrie, ON 705-726-0400

Dr. Anna Lamon, BA, DC ☐
Dr. Tim Lamon, BA, MSc, DC ☐
Dr. Matt Tribe, B.Sc, DC ☑

Confidential Patient Information

Name: Sex: ☐ M ☐ F ☐ NA Date: Month Day 2016

Date of birth _ Age: _ Occupation:

Address:

City: Postal Code:

Phone: Home: Work: Mobile:

Email (If your Dr. needs to email you)

Marital Status: # of Children: Ages:

How did you hear about us?

Current Major Complaint:

How long have you had this condition? Is it getting? ☐ Worse ☐ Better ☐ Constant

Previous diagnosis/treatment for this condition:

Other Complaints:

Have you had previous chiropractic care? When? Who?

Medical Doctor: City:

Any additional Info

May we add you to our informative monthly health email newsletter list? --

If your injuries are related to a motor vehicle accident or workplace injury, please speak to desk staff.

Family Health Information: Many health problems are the result of hereditary spinal weaknesses. Information about your family members will give us a better picture of your total health. Please list your immediate family members who have had any type of illness or disease.

Name	Relationship	Past & Present Health Problems

Please List Any:

Medications you take (including Aspirin, birth control, etc): None

Surgeries, car accidents, falls: None

Overnight hospital stays: None

Broken/fractured bones: None

Canes, crutches or supports you have used: None

Loss of consciousness or altered mental state: None

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Past Medical Conditions

☐ ADD/ADHD	☐ Alcoholism	☐ Allergies	☐ Anemia	☐ Appendicitis
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma	☐ Cancer	☐ Cold Sores
☐ Diabetes	☐ Diphtheria	☐ Eczema	☐ Emphysema	☐ Epilepsy
☐ Heart Disease	☐ Hepatitis	☐ High Blood Pressure	☐ HIV/AIDS	☐ Infertility
☐ Measles	☐ Migraines	☐ Multiple Sclerosis	☐ Mumps	☐ Pertussis
☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Rubella	☐ Stroke
☐ Tetanus	☐ Tuberculosis	☐ Thyroid	☐ Ulcers	☐ Venereal Disease

Other (please specify): _____

Psychosocial Occurrences

☐ Alcohol Increase	☐ Anxiety	☐ Change in job	☐ Chronic Fatigue
☐ Death in the family	☐ Depression	☐ Divorce	☐ Drug Use
☐ Economic Stress	☐ Family Problems	☐ Work Stress	☐ Sleep Disturbances

Other (please specify): _____

Nutrition & Lifestyle

Do you skip meals regularly? _____ If so how often? _____

Coffee/tea Consumption: _____ cups/day Alcohol Consumption: _____ drinks/week

Tobacco Use: _____ per day Vitamins/Supplements: _____

Personal Satisfaction with Diet: _____

What exercise do you do on a regular basis & how often? _____

For women only: When did your last period begin? _____ _____ _____ Are you pregnant? _____

Date of Last

Spinal Examination: _____ _____ _____ Physical Examination: _____ _____ _____

Spinal X-Ray: _____ _____ _____ Other Tests (blood, urine, etc): _____ _____ _____

I agree and understand that I am personally responsible for all charges relating to my care at the clinic. The clinic will provide me with the necessary paperwork upon request in order to make a claim with my health insurance plan. Futhermore, I give the doctor my consent to complete a consultation, physical examination and x-rays if necessary.

Date: Month Day 2016

Signature:

To sign: Tap the signature box and select "customer signature". Sign in the large white box with your fingertip and then select "done" in the top right corner