



Priority Chiropractic
531 Bayfield St., Barrie, ON, 726-0400

Dr. Anna Lamon, BA, DC
Dr. Tim Lamon, BA, MSc, DC
Dr. Christy Inglis, BA Kin, DC
Dr. Dan Warnock, BHK, BSc, DC

Confidential Patient Information

Name _____ Sex M F Date _____

Date of birth: _____ Age _____ Occupation _____
(day/month/year)

Address _____ City _____ Postal Code _____

Phone: Home _____ Work _____ Cell _____

Email _____

Marital Status _____ Children's Names & Ages _____

Which one of our patients referred you/How did you hear about us? _____

Current Major Complaint _____

How long have you had this condition? _____ Is it getting: worse ___ better ___ constant ___

Previous diagnosis and/or treatment for present condition _____

Other Complaints _____

Have you had previous chiropractic care: _____ When? _____ Who? _____

Medical Doctor's Name _____ City _____

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 and Present Health Problems

Please List Any:

Medication you take (including aspirin, birth control, etc.) _____

Surgeries, car accidents, falls _____

Over-night hospital stays _____

Broken/fractured bones you have had _____

Canes, crutches or supports you have used _____



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Loss of consciousness or altered mental states _____

Circle The Conditions You Have Had or Been Treated For

- | | | | | |
|------------------|--------------|---------------------|-----------|------------------|
| 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 | Pertusis |
| Pneumonia | Polio | Rheumatic Fever | Rubella | Stroke |
| Tetanus | Tuberculosis | Thyroid | Ulcers | Venereal Disease |

Other (please specify) _____

Psychosocial: Have any of the following occurred recently?

- | | | | |
|---------------------|-----------------|---------------|--------------------|
| 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 and Lifestyle

Do you skip meals regularly? If so, how often? _____ Coffee/tea Consumption _____ cups per day

Alcoholic Beverages _____ drinks per week Tobacco Use _____ per day

List all vitamins or supplements you take. _____

Personal Satisfaction with Diet: Highly satisfied ___ Satisfied ___ Unsatisfied ___ Highly Unsatisfied ___

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

For Women Only: When did your last period start? _____ Are you pregnant? Yes No Maybe

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. Furthermore, I give the doctor my consent to complete a consultation, physical examination and x-rays if necessary.

Date: _____ Signature: _____



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Date: _____ Guardian: _____

(if patient is under 18 years of age)