Dr. Rebecca Cannon ND

69 Arthur St S Suite #204 Elmira, ON N3B 2M8

Name: _____ Date: _____
Address: _____
City: _____ Province: _____
Postal Code: _____ Home Phone: _____
Business Phone: _____ Cell Phone: _____
Email address: _____
Sex: M F Age:_____ Date and Place of birth: _____
Occupation: _____ Employer: _____
Marital Status: _____ Ages of Children:_____
Emergency Contact: _____ Phone: _____
How did you hear about the office? _____
Is there anyone else on your health care team? (RMT, Chiropractor, Osteopath, Physiotherapist)
_____
_____

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize me to do so.

What are your health concerns; why are you here today?
_____
_____

Please list any medications or supplements you are taking with dosage for each:
_____
_____
_____

Please list any major surgeries or hospitalizations in your past with dates for each:
_____
_____
_____

Are you up to date on all your childhood vaccines?: _____
Are there any vaccines you opted not to have?: _____
Are there any extra vaccines you have taken?: _____
Did you experience any adverse effects from any of the vaccines? If yes, please explain:
_____

Please indicate if a family member (sibling, parent, grandparent) has had any of the following:
Arthritis ___ Asthma ___ Cancer ___ Diabetes ___ Eczema ___ Gallstones ___
Heart Disease ___High Blood Pressure ___ Kidney Disease ___ Mental Illness ___ Multiple Sclerosis ___ TB ___Osteoporosis ___ Skin Disease ___ Stroke ___ Thyroid Disease ___
Other_____
Do you smoke? Y N If so, how many per day? _____
Do you drink the following? Tea Coffee Pop Diet Pop How Many per Day? _____
Do you drink alcohol? Y N How many drinks in a week? _____
Do you use any recreational drugs? Y N Which ones?_____
How frequently do you move your bowels? _____(# of movements) per day

How many hours of sleep do you get on a daily average? _____
Do you wake refreshed? Y N
Has anyone reported anything unusual you do in your sleep? _____
How many hours a day do you work?_____
Do you exercise? Y N If yes, how often and what do you do for exercise?
_____
Food allergies or intolerances: _____
Environmental allergies or intolerances: _____
What are your favourite things to eat? _____
What foods do you like to avoid? _____
Are there any foods that make you ill? _____
Are you able to skip a meal? Y N If no, what happens? _____

I attest that the information provided is true and accurate to the best of my knowledge. I hereby provide consent to the touch and treatment provided for the purpose of physical examination and patient care.
Signature: _____ Date: _____

I authorize Rebecca Cannon ND to contact me via electronic mail (email). I am aware that the office of Rebecca Cannon ND does not have encrypted email software and cannot guarantee that information transmitted via email will not be intercepted by other parties. By signing this form, I agree not to hold Rebecca Cannon ND responsible for any breach of confidentiality that may occur by someone else accessing the information contained in any emails sent to or from Rebecca Cannon ND regarding my personal health information. I understand that reasonable means will be used to protect the security and confidentiality of the email. My email will not be forwarded outside the office without my consent.
Signature: _____ Date: _____