BELL CHIROPRACTIC
26 Colborne St E
Orillia ON L3V 1T3
(705) 326-2200

GENERAL INTAKE FORM

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Phone: Home: _____
Work: _____
City: _____ Postal Code: _____ Cell: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Title: ☐ Mrs. ☐ Mr. ☐ Ms. ☐ Dr. Email: _____

Occupation: _____ Medical Doctor: _____

Referred to: _____ Referred by: _____

Treatment type: ☐ PHYSIOTHERAPY ☐ CHIROPRACTIC ☐ KINESIOLOGY
☐ MASSAGE THERAPY ☐ ACTIVE RELEASE TECHNIQUE®

Type of Injury
Is this a Workplace Safety & Insurance Board Injury? ☐ Yes ☐ No
Are your injuries related to a motor vehicle accident case? ☐ Yes ☐ No

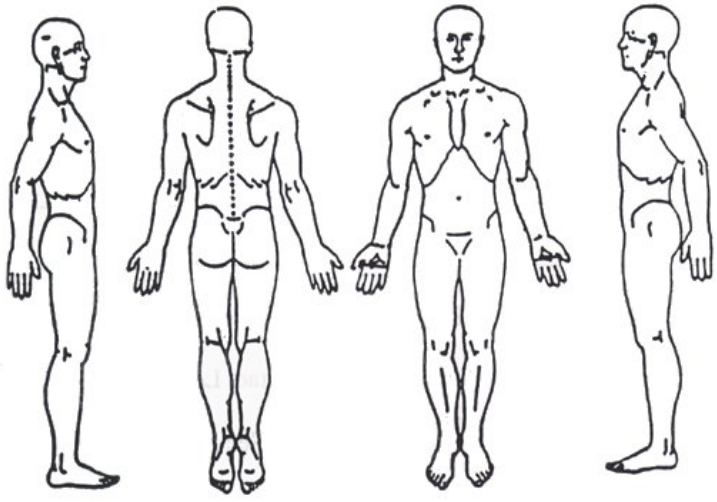
Please provide a brief description of your current pain or injury: _____
_____

Duration of symptoms: _____ Have you had these symptoms before? ☐ Yes ☐ No
This condition is:
☐ Constant ☐ Comes & Goes ☐ Progressively Worse ☐ Progressively Improving
Symptoms are interfering with: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sport

Please indicate your current pain level with a slash on the line below.

NO PAIN AT ALL _____ PAIN AS BAD AS IT COULD BE

On the following diagrams, please indicate ***all areas*** causing:
PAIN (mark with **xxx**'s)
STIFFNESS (mark with ***///***'s)
NUMBNESS (mark with **ooo**'s)
OTHER – (explain _____
_____)



Have you received previous care for these symptoms? ☐ Yes ☐ No
If Yes: When: _____ Where: _____