

BACK TO FUNCTION

26 Colborne St E
Orillia ON L3V 1T3
(705) 326-9977

GENERAL INTAKE FORM

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Phone: Home: _____

City: _____ Postal Code: _____ Work: _____
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

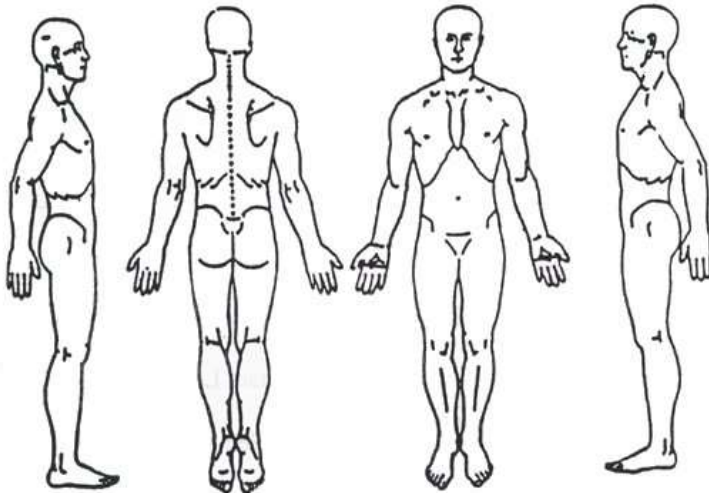
On the following diagrams, please indicate **all areas** causing:

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: _____