INITIAL INTAKE FORM

PATIENT INFORMATION

Name:				Date:				
Birthday (Y/M/D):				Gender:				
	City							
Home Ph. #:	Cell:		En					
Occupation:			En	nployer:				
How did you hear about thi								
Name of Medical Doctor: _			Permission	n to update your MI	O on care: Y / N			
			Emergency Contact Number:					
WHAT IS THE REASON F	OR YOUR VISIT 1	TODAY?						
What is your primary comp	laint today?							
How long have you had this	s condition?							
How did the condition start	?							
Is the condition getting: (cir	cle) Worse	Same	Better	Consistent	Recurring			
How would you describe th	e pain? (circle)	Achy	Throbbing	Tingling Nur	nbness			
		Burnir	ng Shoo	ting Intermitten	t Constant			
Do you experience Numbne	ess or Tingling to t	he arms o	or legs?	Yes / No				
Is there time of day when y	our symptoms are	worse? (circle) Morn	ing / Afternoon / Ev	ening / Night /			
				After Activities				
Are there activities are you	unable to perform	due to yo	our complair	nt? (i.e., Work, Hob	bies, Sleep)			
Have you had this condition	n before? Yes	/ No						
Were X-RAYS or other ima	ging performed?	Yes / N	10					
What aggravates your cond	dition?							
What relieves your conditio	n?							

Gray Chiropractic Spine & Joint Clinic
40 Tulip Tree Common, St. Catharines, Ontario, L2S 3Y9
___ Dr. Jason Gray, DC
___ Dr. Stephanie Gray, DC

GRAY CHIROPRACTIC SPINE & JOINT CLINIC - INITIAL INTAKE FORM

Name:		Date:				
Have you had any treatment for this condition? _						
Have you had previous chiropractic care? Y / N	(If "yes" how	long has it been since?)				
FAMILY & PERSONAL HISTORY						
Do you currently suffer from any of the following?	?					
() Unexplained weight loss () Fever	or chills	() Difficulty Sleeping				
() Pain that awakens you at night () Night	sweats	() General Tiredness/ Fatigue				
() Recent changes with bladder or bowel fund	ction	() Recent illness or infection				
Please list family members (or yourself) who have	e the following	g conditions:				
Cancer:	Autoimmun	Autoimmune Disease:				
Skin Disorders:	Arthritis:					
Heart Disease:	Allergies/Environmental Illness:					
High Blood Pressure:	Respiratory/Environmental Illness:					
Stroke:	Addictions:					
Diabetes:	Liver Disease:					
Thyroid Disease:	Prostate Disease:					
Mental Illness:	Neurological Ds (ie. MS, Parkinsons)					
List Any Hospitalizations, Surgeries, Major Accide	entslinjuries, 2	X-rays, CAT Scans, MRIs, EKGs, etc:				
Please list any medications you are currently taking	J					
HEALTH HABITS						
	packs/day					
Do you smoke? Y / N If "yes" how many years? _						

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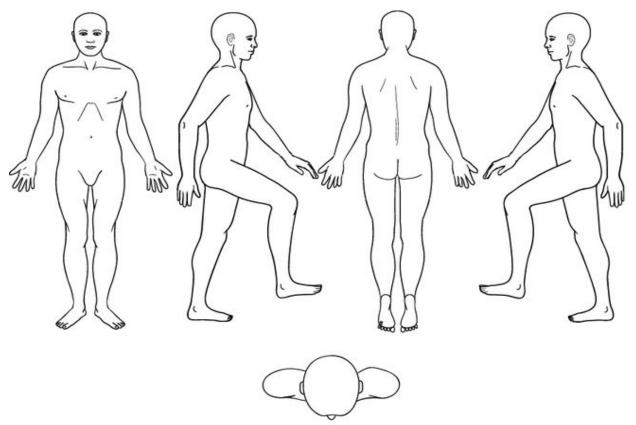
PAIN DRAWING

Name:	Date:
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Please be sure to fill this out *extremely* accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well if it applies.

Numbness: ----- Pins & Needles: 000000000 Burning Pain xxxxxxxxx

Stabbing Pain: ////////// Aching Pain: (((((((((((



VISUAL ANALOGUE SCALE

Please mark on the line the pain level that most accurately represents your pain:

NO PAIN	0	1 2	3	4 5	6	7 8	9 1	0 L	JNBEAF	RABLE	PAIN
a) Right Now:	0	1	2	3	4	5	6	7	8	9	10
b) Average Pain:	0	1	2	3	4	5	6	7	8	9	10
c) At Best:	0	1	2	3	4	5	6	7	8	9	10
d) At Worst:	0	1	2	3	4	5	6	7	8	9	10

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Gray Chiropractic Fee Schedule

Initial Consultation: \$90.00

MVA Initial Consultation \$215.00

Subsequent Chiropractic Treatments: \$60.00

Custom-Orthotics: \$400.00

Cancellation Policy

We kindly ask that appointments are cancelled or rescheduled <u>24 hours in advance</u>. We understand that situations arise that may result in one's ability not to comply with this request. A <u>missed appointment fee of \$20 may</u> be applied at the doctor's discretion after the third offence.

Updated October 18, 2016

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