Neck Intake Form

Patient Information:

Name: _____ Date: _____

Cell #: _____ Home #: _____ Email: _____

Address: _____ City: _____ Postal Code:_____

Gender: _____Birthdate: _____ Age: _____

Occupation: _____ Employer: _____

Name of Medical Doctor: _____ Permission to update your MD on care: Y / N

Name of emergency contact: _____ Emergency contact #:_____ _____

Do you have extended health benefits? Y / N Name of insurance company?_____

How did you hear about this clinic?: _____

Do you consent to our office emailing you or phoning you? Y / N

What is the Reason For Your Visit Today?

What is your primary complaint today? _____

How long have you had this condition? _____

How did the condition start?_____

Is the condition getting: *(circle)* Worse Same Better Consistent Recurring

How would you describe the pain? *(circle)* Achy Throbbing Tingling Numbness Burning Shooting Intermittent Constant

Do you experience numbness or tingling to the arms or legs? Yes / No

Is there time of day when your symptoms are worse? *(circle)* morning / afternoon / evening / night / after activities

Are there activities are you unable to perform due to your complaint? (i.e., work, hobbies, sleep)

_____

Have you had this condition before? Yes / No

Were X-RAYS or other imaging performed? Yes / No

What aggravates your condition? _____

What relieves your condition? _____

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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?) _____

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 function ( ) recent illness or infection

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune Disease:
Skin Disorders:	Arthritis:
Heart Disease:	Allergies/Environmental Illness:
High Blood Pressure:	Respiratory Illness:
Stroke:	Addictions:
Diabetes:	Liver Disease:
Thyroid Disease:	Prostate Disease:
Mental Illness:	Neurological Ds (ie. MS, Parkinsons, fibromyalgia)

List any hospitalizations, surgeries, major accidents, injuries, x-rays, CAT Scans, MRIs, EKGs, etc:

_____

_____

Please list any medications you are currently taking:

_____

_____

Health Habits: Do you smoke? Y / N If "yes" how many years? ____ packs/day_____

Do you regularly exercise Y / N (If "Yes" how many times a week:_____)

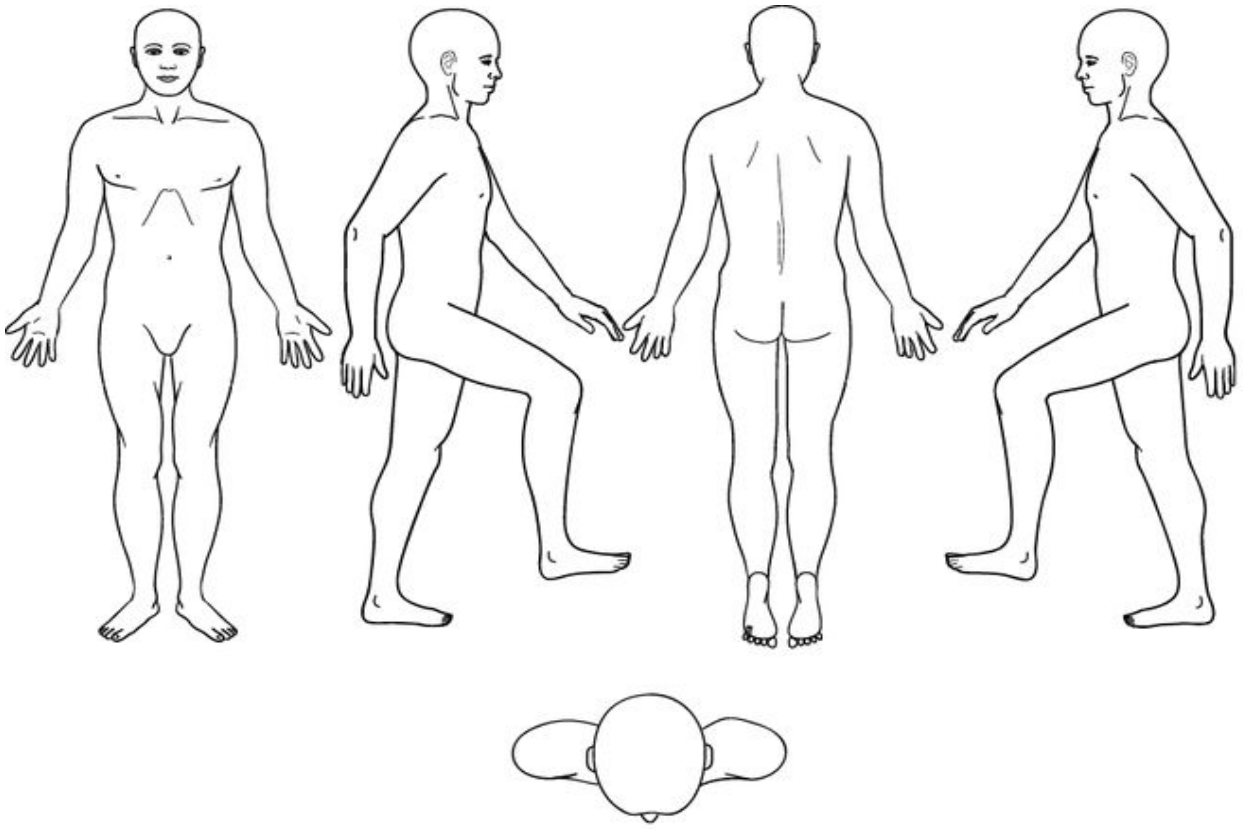
Name: _____ Date: _____

Pain Drawing

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.

Numbness: ---------- Pins & Needles: oooooooo 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	10	UNBEARABLE 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	

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

Name: _____ Date: _____

Gray Chiropractic Fee Schedule

Initial Consultation:	$90.00
Subsequent Chiropractic Treatments:	$60.00
Re-examination	$60.00
Custom-Orthotics:	$400.00

Cancellation Policy

We kindly ask that appointments are cancelled or rescheduled **24 hours in advance**. We understand that situations arise that may result in one's ability not to comply with this request. A missed appointment fee of $20.00 may be applied at the doctor's discretion after the third offence.

Updated December 10, 2018

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

Neck Pain Disability Index Questionnaire:

Name: _____ Date: _____

How much has your neck pain affected your ability to manage your everyday activities?
Circle ONE choice that most applies to you right now.

Pain Intensity: ❑ I have no pain at the moment. ❑ The pain is very mild at the moment. ❑ The pain is moderate at the moment. ❑ The pain is fairly severe at the moment. ❑ The pain is the worst imaginable at the moment.	Concentration: ❑ I can concentrate fully when I want to with no difficulty. ❑ I can concentrate fully when I want to with slight difficulty. ❑ I have a fair degree of difficulty concentrating when I want to. ❑ I have a lot of difficulty concentrating when I want to. ❑ I have a great deal of difficulty concentrating when I want to. ❑ I cannot concentrate at all.
Work: ❑ I can do as much work as I want to ❑ I can only do my usual work, but no more ❑ I can do most of my usual work, but no more ❑ I cannot do my usual work ❑ I can hardly do any work at all ❑ I cannot do any work at all	Sleeping: ❑ I have no trouble sleeping ❑ My sleep is slightly disturbed (less than 1 hour of sleepless) ❑ My sleep is mildly disturbed (1-2 hours sleepless) ❑ My sleep is moderately disturbed (2-3 hours sleepless) ❑ My sleep is greatly disturbed (3-5 hours sleepless) ❑ My sleep is completely disturbed (5-7 hours)
Lifting: ❑ I can lift heavy weights without extra pain ❑ I can lift heavy weights, but it gives extra pain ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (eg. on a table) ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned ❑ I can lift very light weights ❑ I cannot lift or carry anything at all	Driving: ❑ I can drive my car without any neck pain. ❑ I can drive my car as long as I want with slight pain in my neck. ❑ I can drive my car as long as I want with moderate pain in my neck. ❑ I cannot drive my car as long as I want because of moderate pain in my neck. ❑ I can hardly drive at all because of severe pain in my neck. ❑ I cannot drive my car at all.
Reading: ❑ I can read as much as I want to with no pain in my neck ❑ I can read as much as I want to with slight pain in my neck. ❑ I cannot read as much as I want because of moderate pain in my neck. ❑ I cannot read as much as I want because of severe pain in my neck. ❑ I cannot read at all.	Recreation: ❑ I am able to engage in all of my recreational activities with no neck pain at all. ❑ I am able to engage in all of my recreational activities with some pain in my neck. ❑ I am able to engage in most, but not all of my recreational activities because of pain in my neck. ❑ I can hardly do any recreational activities because of pain in my neck. ❑ I cannot so any recreational activities at all.
Headaches: ❑ I have no headaches at all. ❑ I have slight headaches which com infrequently ❑ I have moderate headaches which come infrequently. ❑ I have severe headaches which come frequently. ❑ I have headaches almost all the time.	Personal Care (Washing, Dressing, etc): ❑ I can look after myself normally without causing extra pain. ❑ I can look after myself normally, but it causes extra pain. ❑ It is painful to look after myself and I am slow and careful. ❑ I need some help but I manage most of my personal care. ❑ I need help everyday in most aspects of self care. ❑ I do not get dressed, I wash with difficulty and stay in bed.

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