Upper Extremity 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

Emergency contact: _________________ Emergency contact number: __________________

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

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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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 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
Stroke:	Addictions:
Diabetes:	Liver Disease:
Thyroid Disease:	Prostate Disease:
Mental Illness:	Neurological Ds (ie. MS, Parkinsons)

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 often _______________ times/week_______________

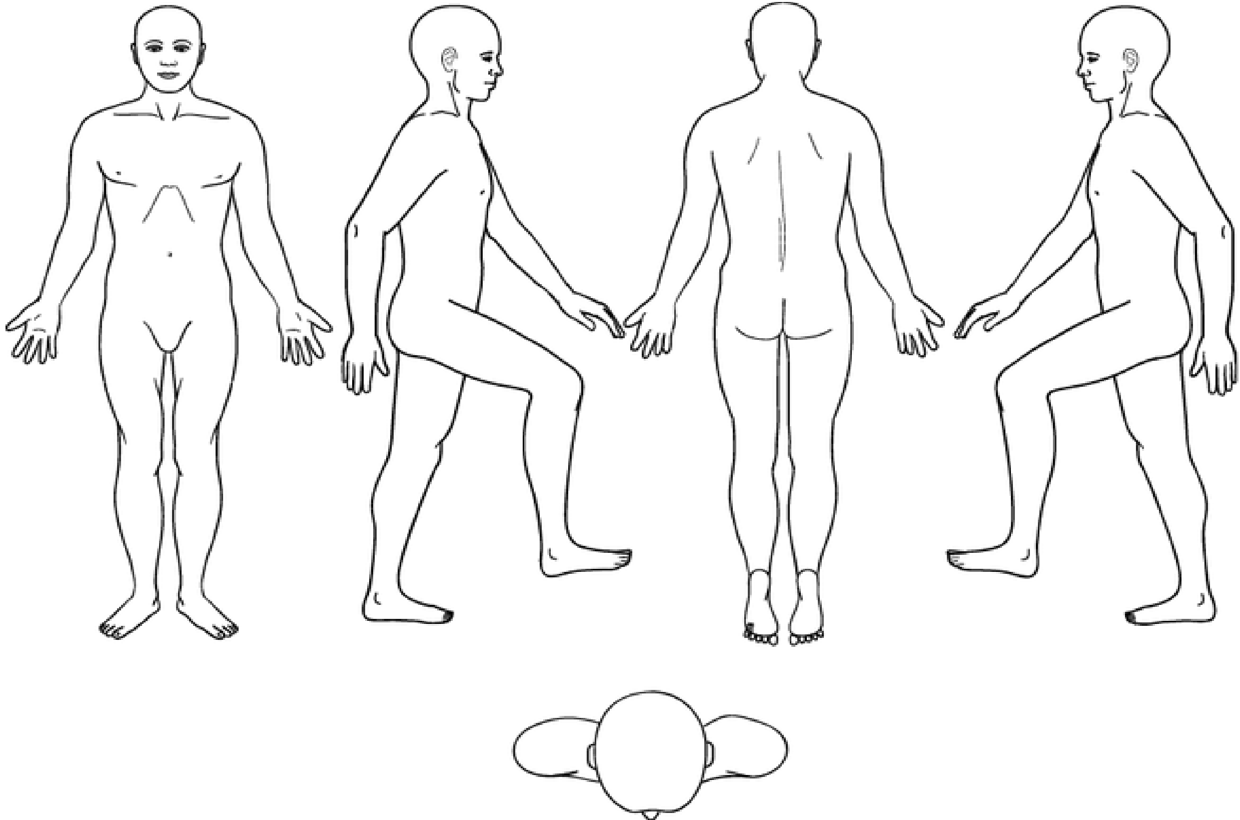
Upper Extremity Pain Drawing:

Name: ____ Date: ___________________

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: ooooooooo** **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	

Name: ____ Date: ___________________

Gray Chiropractic Fee Schedule

Initial Consultation:	$90.00
Subsequent Chiropractic Treatments:	$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** may be applied at the doctor's discretion after the third offence.

Updated December 12,, 2018

Name: ____ Date: _________________

The Upper Extremity Functional Index (UEFI)

Do you have any difficulty at all with the activities listed below *because of your upper limb problem* for which you are currently seeking attention today? Please Rate Your Difficulty for each and every activity from 0 to 4:

0: Extreme difficulty or unable to perform activity **1:** Quite a bit of difficulty
2: moderate difficulty **3:** A little bit of difficulty **4:** no difficulty

#	Activity	Rate
1	Usual work, housework, or school activities	0 1 2 3 4
2	Usual hobbies, recreational / sporting activities	0 1 2 3 4
3	Lifting a bag of groceries to waist level	0 1 2 3 4
4	Lifting a bag of groceries above your head	0 1 2 3 4
5	Grooming your hair	0 1 2 3 4
6	Pushing up on your hands (eg. from chair or bathtub)	0 1 2 3 4
7	Preparing food (eg. peeling, cutting)	0 1 2 3 4
8	driving	0 1 2 3 4
9	Vacuuming, sweeping, raking	0 1 2 3 4
10	Dressing	0 1 2 3 4
11	Doing up buttons	0 1 2 3 4
12	Using tools or appliances	0 1 2 3 4
13	Opening doors	0 1 2 3 4
14	Cleaning	0 1 2 3 4
15	Tying or lacing shoes	0 1 2 3 4
16	Sleeping	0 1 2 3 4
17	Laundry (washing, folding, ironing)	0 1 2 3 4
18	Opening a jar	0 1 2 3 4
19	Throwing a ball	0 1 2 3 4
20	Carrying a small suitcase with your affected limb	0 1 2 3 4
	Column Total:	Score: _______ / 80

Minimum level of detectable change (90% confidence): 9 points

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