Lower 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 #: _____

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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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 many times a week: _____)

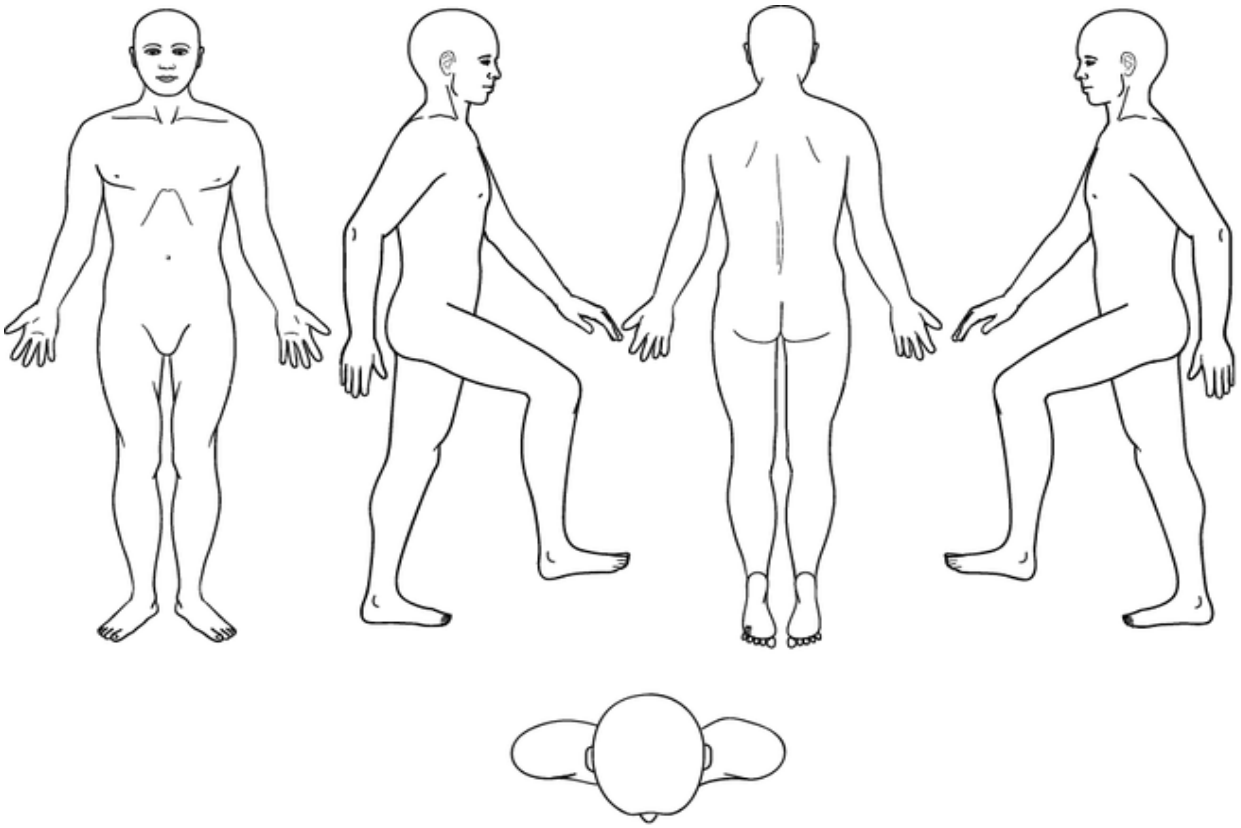
Pain Drawing:

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.

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

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:	$100.00
Subsequent Chiropractic Treatments:	$60.00
Re-Examination	$75.00
Custom-Orthotics:	$450.00

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 January 2,2023

__ Dr. Jason Gray, DC
__ Dr. Stephanie Gray, DC

Name: _____ Date: _____

The Lower Extremity Functional Index:

Do you have any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention? Please provide an answer for each activity.

0: Extreme Difficulty or Unable to Perform Activity 1: Quite A Bit Difficult
2: Moderate Difficulty 3: A Little Bit of Difficulty 4: No Difficulty

Today, do you or would you, have any difficulty at all with:

Activities:	Refer To Scale: 0 - 4				
Usual work (household, work, school activities)	0	1	2	3	4
Usual hobbies (recreational, sporting)	0	1	2	3	4
Getting into/out of the bath	0	1	2	3	4
Walking between rooms	0	1	2	3	4
Putting on shoes or socks	0	1	2	3	4
Squatting	0	1	2	3	4
Lifting an object: like a bag of groceries from the floor	0	1	2	3	4
Performing light activities around your home	0	1	2	3	4
Performing heavy activities around your home	0	1	2	3	4
Getting in or out of car	0	1	2	3	4
Walking 2 blocks	0	1	2	3	4
Walking 1 mile	0	1	2	3	4
Going up or down 1 flight (10 stairs)	0	1	2	3	4
Standing for 1 hour	0	1	2	3	4
Sitting for 1 hour	0	1	2	3	4
Running on even ground	0	1	2	3	4
Running on uneven ground	0	1	2	3	4
Making sharp turn while running fast	0	1	2	3	4
Hopping	0	1	2	3	4
Rolling over in bed	0	1	2	3	4

Minimum level of detectable change (90% confidence): 9 points Score: _____ / 80