Lower Back 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

Is there a 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? _____

Low Back 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 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)

List any hospitalizations, surgeries, major accidents, injuries, X-rays, CT 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: _____)

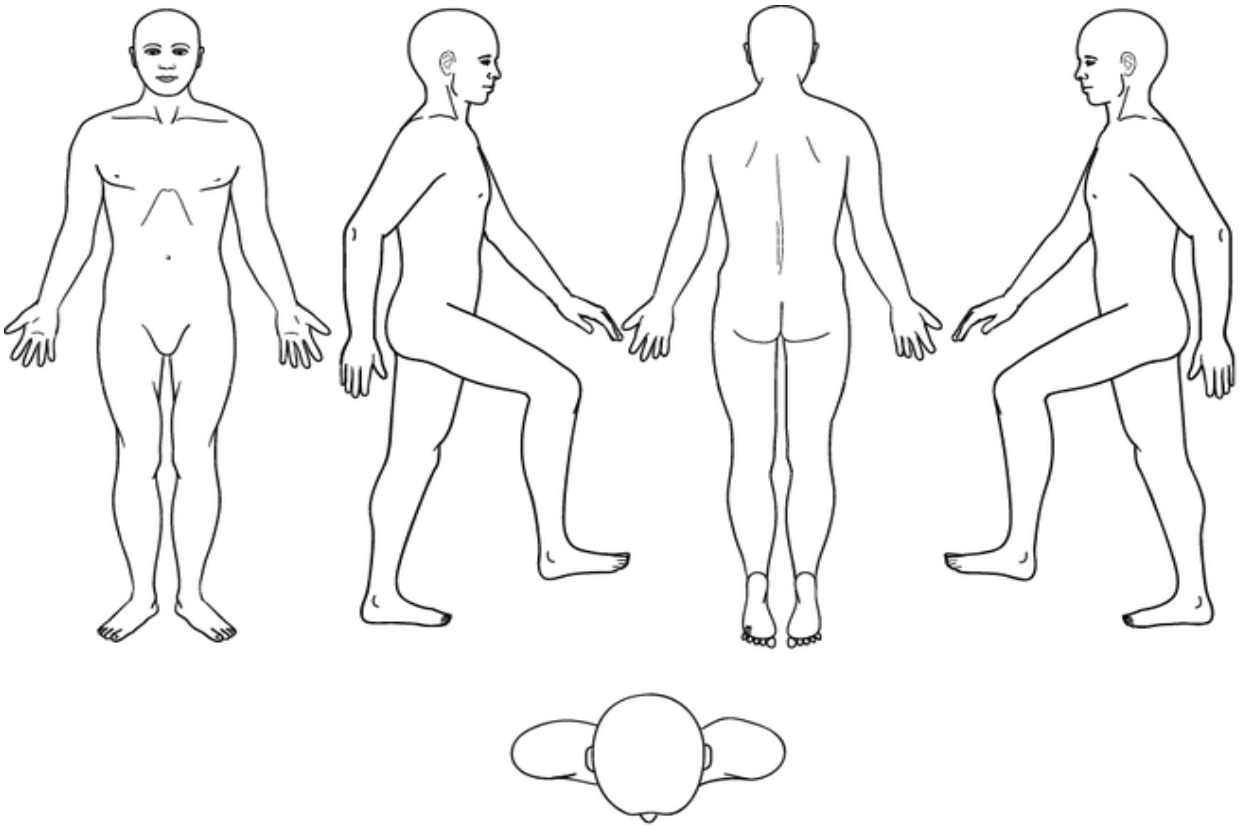
Lower Back Pain Drawing:

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
Re-examination:	$75
Subsequent Chiropractic Treatments:	$60.00
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

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

Oswestry Low Back Pain Scale

Name: _____ Date: _____

Instructions: Please circle the ONE Number in each section which most closely describes your problem.

Section 1: Pain Intensity 0. The pain comes and goes and is very mild. 1. The pain is mild and does not vary much. 2. The pain comes and goes and is moderate. 3. The pain is moderate and does not vary much. 4. The pain comes and goes and is severe. 5. The pain is severe and does not vary much.	Section 6: Standing 0. I can stand as long as I want without pain. 1. I have some pain on standing but it does not increase with time. 2. I can not stand for longer than 1 hour without increasing pain. 3. I can not stand for longer than ½ hour without increasing pain. 4. I can not stand for longer than 10 min. without increasing pain. 5. I avoid standing because it increases the pain immediately
Section 2: Personal Care 0. To Avoid Pain, I do not have to change my way of washing or dressing. 1. I do not normally change my way of washing or dressing even though it causes some pain. 2. Washing and dressing increase the pain but I manage not to change my way of doing it. 3. Washing and dressing increase the pain and I find it necessary to change my way of doing it. 4. Because of the pain I am unable to do some washing and dressing without help 5. Because of the pain I am unable to do any washing and dressing without help.	Section 7: Sleeping 0. I get no pain in bed. 1. I get pain in bed but it does not prevent me from sleeping well. 2. Pain reduced my normal night's sleep by less than one-quarter. 3.Pain reduces my normal night's sleep by less than one-half. 4. Pain reduces my normal night's sleep by less than three-quarters. 5. Pain prevents me from sleeping at all.
Section 3: Lifting 0. I can lift heavy weights without extra pain. 1. I can lift heavy weights but it gives extra pain. 2. Pain prevents me lifting heavy weights off the floor. 3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned. eg. on a table. 4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. 5. I can only lift very light weights at most.	Section 8: Social Life 0. My social life is normal and gives me no pain. 1. My social life is normal but it increases the degree of pain. 2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc. 3. Pain has restricted my social life and I do not go out very often. 4. Pain has restricted my social life to my home. 5. I have hardly any social life because of the pain.
Section 4: Walking 0. I have no pain on walking 1. I have some pain but it does not increase with distance. 2. I cannot walk more than 1 mile without increasing pain. 3. I cannot walk more than ½ mile without increasing pain. 4. I cannot walk more than ¼ mile without increasing pain. 5. I cannot walk at all without increasing pain.	Section 9: Travelling 0. I get no pain when traveling. 1. I get some pain when traveling but none of my usual forms of travel make it any worse. 2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel. 3. I get extra pain while traveling which compels me to seek alternative forms of travel. 4. Pain restricts me to short necessary journeys under ½ hour. 5. Pain restricts all forms of travel.
Section 5: Sitting 0. I can sit in any chair as long as I like 1. I can sit only in my favourite chair as long as I like. 2. Pain prevents me from sitting more than 1 hour. 3. Pain prevents me from sitting more than ½ hour. 4. Pain prevents me from sitting more than 10 minutes. 5. I avoid sitting because it increases pain immediately.	Section 10: Changing Degree of Pain 0. My pain is rapidly getting better. 1. My pain fluctuates but is definitely getting better. 2. My pain seems to be getting better but improvement is slow. 3. My pain is neither getting better or worse. 4. My pain is gradually worsening. 5. My pain is rapidly worsening.

Total: _____

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