



## Neck 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?) \_\_\_\_\_

### Family & Personal History:

Do you currently suffer from any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> unexplained weight loss                       | <input type="checkbox"/> fever or chills             | <input type="checkbox"/> difficulty sleeping         |
| <input type="checkbox"/> pain that awakens you at night                | <input type="checkbox"/> night sweats                | <input type="checkbox"/> general tiredness / fatigue |
| <input type="checkbox"/> recent changes with bladder or bowel function | <input type="checkbox"/> 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 \_\_\_\_\_

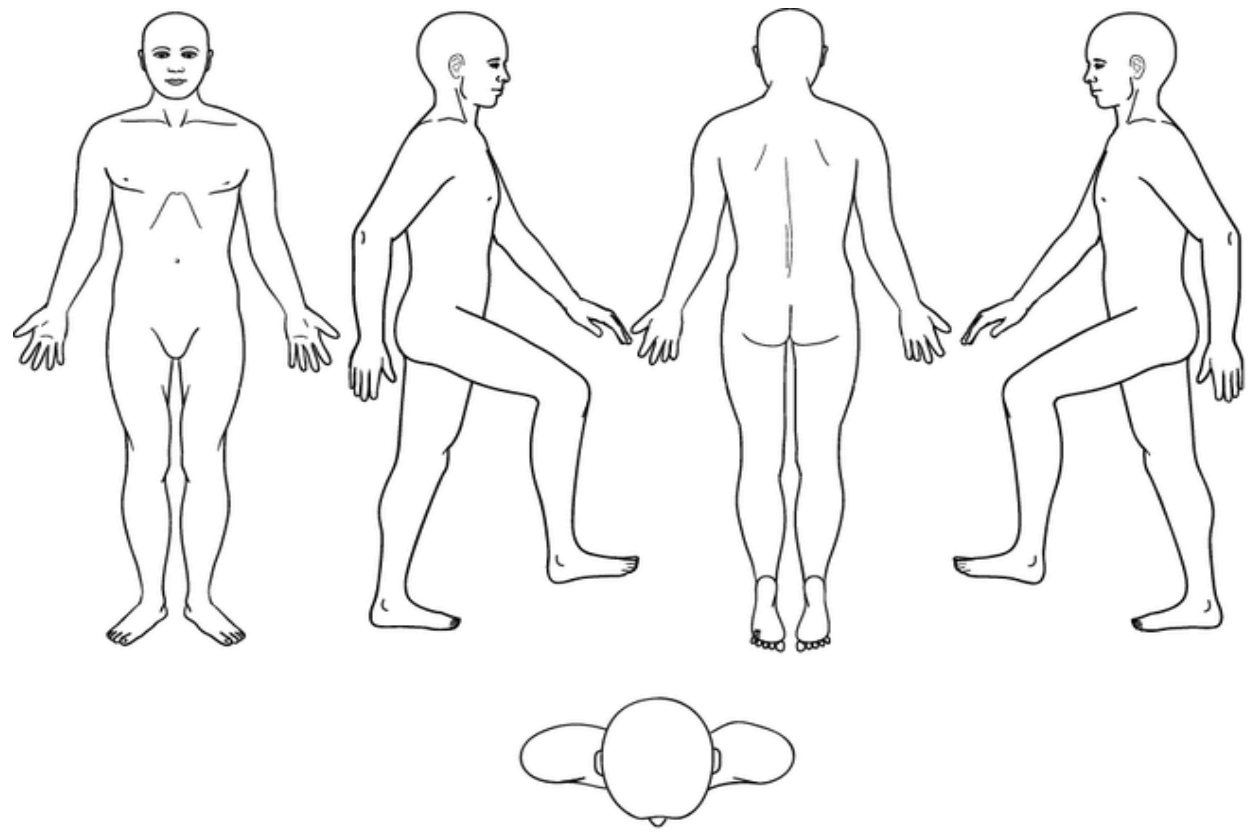
Do you regularly exercise Y / N (If "Yes" how many times a week: \_\_\_\_\_)

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:** oooooooooo    **Burning Pain** xxxxxxxxxx  
**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:	\$120.00
Re-examination:	\$80.00
Subsequent Chiropractic Treatments:	\$65.00
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 may be applied at the doctor's discretion.

Updated November/25

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.

<p><u>Pain Intensity:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no pain at the moment.</li> <li><input type="checkbox"/> The pain is very mild at the moment.</li> <li><input type="checkbox"/> The pain is moderate at the moment.</li> <li><input type="checkbox"/> The pain is fairly severe at the moment.</li> <li><input type="checkbox"/> The pain is the worst imaginable at the moment.</li> </ul>	<p><u>Concentration:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</li> <li><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</li> <li><input type="checkbox"/> I have a fair degree of difficulty concentrating when I want to.</li> <li><input type="checkbox"/> I have a lot of difficulty concentrating when I want to.</li> <li><input type="checkbox"/> I have a great deal of difficulty concentrating when I want to.</li> <li><input type="checkbox"/> I cannot concentrate at all.</li> </ul>
<p><u>Work:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can do as much work as I want to</li> <li><input type="checkbox"/> I can only do my usual work, but no more</li> <li><input type="checkbox"/> I can do most of my usual work, but no more</li> <li><input type="checkbox"/> I cannot do my usual work</li> <li><input type="checkbox"/> I can hardly do any work at all</li> <li><input type="checkbox"/> I cannot do any work at all</li> </ul>	<p><u>Sleeping:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no trouble sleeping</li> <li><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour of sleepless)</li> <li><input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless)</li> <li><input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless)</li> <li><input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless)</li> <li><input type="checkbox"/> My sleep is completely disturbed (5-7 hours)</li> </ul>
<p><u>Lifting:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without extra pain</li> <li><input type="checkbox"/> I can lift heavy weights, but it gives extra pain</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (eg. on a table)</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned</li> <li><input type="checkbox"/> I can lift very light weights</li> <li><input type="checkbox"/> I cannot lift or carry anything at all</li> </ul>	<p><u>Driving:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can drive my car without any neck pain.</li> <li><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck.</li> <li><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck.</li> <li><input type="checkbox"/> I cannot drive my car as long as I want because of moderate pain in my neck.</li> <li><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck.</li> <li><input type="checkbox"/> I cannot drive my car at all.</li> </ul>
<p><u>Reading:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can read as much as I want to with no pain in my neck</li> <li><input type="checkbox"/> I can read as much as I want to with slight pain in my neck.</li> <li><input type="checkbox"/> I cannot read as much as I want because of moderate pain in my neck.</li> <li><input type="checkbox"/> I cannot read as much as I want because of severe pain in my neck.</li> <li><input type="checkbox"/> I cannot read at all.</li> </ul>	<p><u>Recreation:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I am able to engage in all of my recreational activities with no neck pain at all.</li> <li><input type="checkbox"/> I am able to engage in all of my recreational activities with some pain in my neck.</li> <li><input type="checkbox"/> I am able to engage in most, but not all of my recreational activities because of pain in my neck.</li> <li><input type="checkbox"/> I can hardly do any recreational activities because of pain in my neck.</li> <li><input type="checkbox"/> I cannot so any recreational activities at all.</li> </ul>
<p><u>Headaches:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no headaches at all.</li> <li><input type="checkbox"/> I have slight headaches which com infrequently</li> <li><input type="checkbox"/> I have moderate headaches which come infrequently.</li> <li><input type="checkbox"/> I have severe headaches which come frequently.</li> <li><input type="checkbox"/> I have headaches almost all the time.</li> </ul>	<p><u>Personal Care (Washing, Dressing, etc):</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can look after myself normally without causing extra pain.</li> <li><input type="checkbox"/> I can look after myself normally, but it causes extra pain.</li> <li><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</li> <li><input type="checkbox"/> I need some help but I manage most of my personal care.</li> <li><input type="checkbox"/> I need help everyday in most aspects of self care.</li> <li><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.</li> </ul>