



## Upper Extremity 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?

- |  |  |   |
|--|--|---|
| <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
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:

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Please list any medications you are currently taking:

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### **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 \_\_\_\_\_

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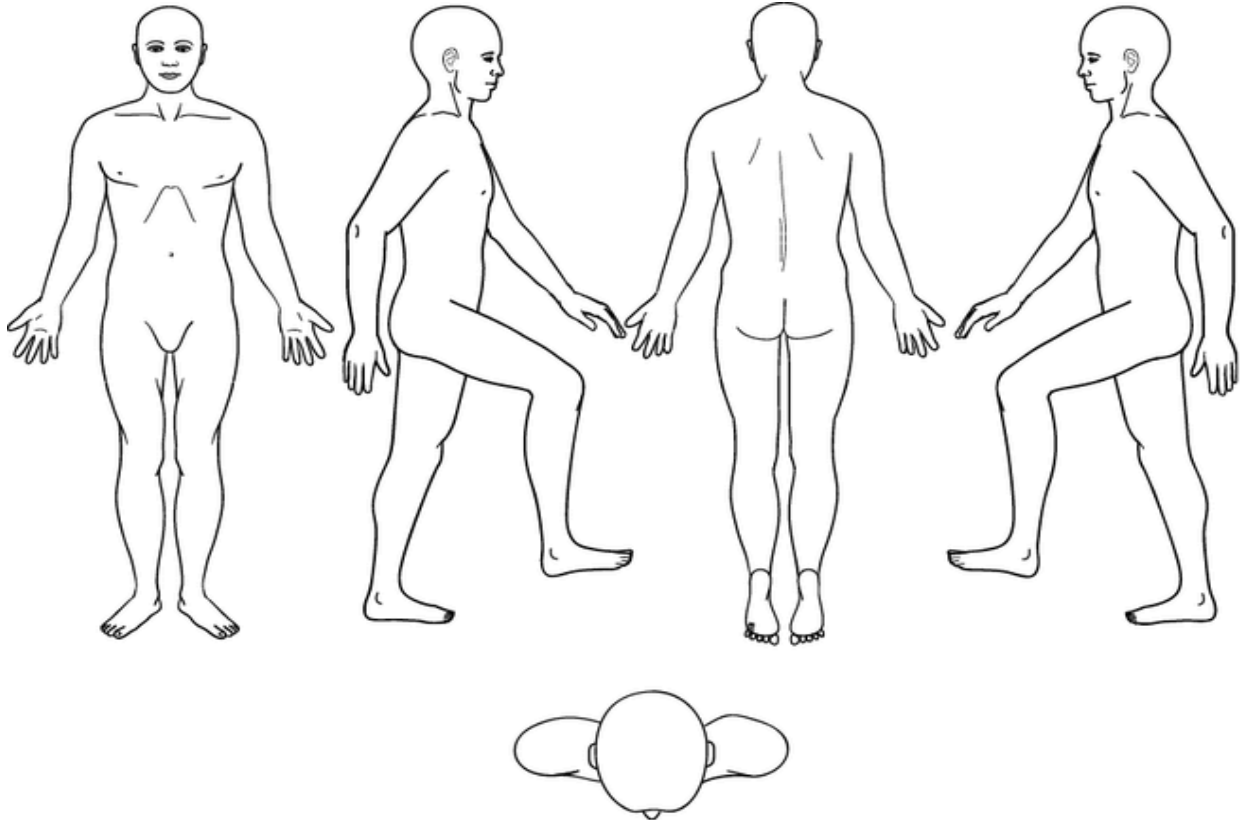
\_\_\_ Dr. Jason Gray, DC \_\_\_ Dr. Stephanie Gray, DC

## 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:** 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	

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## **Gray Chiropractic Fee Schedule**

Initial Consultation:	\$120.00
Re-examination:	\$80.00
Subsequent Chiropractic Treatments:	\$65.00
Custom-Orthotics:	\$450.00

## **Cancellation Policy**

### 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 2025

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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

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