CHRONIC CONDITIONS
CENTER OF GREENSBORO

403 Parkway, Suite A, Greensboro, NC 27401
336-285-7077

Welcome!

The following is information regarding your first visit at Chronic Conditions Center of Greensboro. Your appointment has been scheduled under the assumption that your paperwork will have been completed prior to your appointment time.

When filling out the Symptoms Survey form, please follow the directions carefully. Mark the box "1" for mild symptoms, "2" for moderate, and "3" for severe. If the symptom does not apply to you, leave the box blank.

If you arrive without all of your paperwork completed, you will not been seen by the doctor. You will be asked to reschedule.

When you come in for your appointment, please:

- Bring your completed New Patient Paperwork (enclosed)
- Bring copies of previous x-ray's, MRI's, and lab results
- Please do not wear makeup or fingernail polish on your first visit (will inhibit exam results)
- Please do not chew gum
- Do not drink coffee within 2 hours of your appointment

Please note that our office does not file for your insurance. You may ask for a Superbill that you can submit to your insurance for re-imbursement. We look forward to working with you and re-establishing your health and wellness. If you have any questions, please give our office a call (336) 285-7077.

Kind Regards,
Chronic Condition Center Team

Health and Wellness – Intake Form

Welcome to Chronic Conditions Center of Greensboro. Please be completely accurate and answer each question. Your answers to the following questions are the first step in determining your immediate and long term health care needs. Please elaborate on any question or add any comments you have…the more we know about your needs and concerns, the better we can serve you. Be assured that your information is held in the utmost of confidentiality. Thank you!

Personal Information:

Full Name:			Today's Date:
Date of Birth:	Age:	Height:	Weight:
Address:			
City:		State:	Zip Code:
Primary Phone:		Work Phone:	
Email Address:			
Marital Status: M S D W	Pregnant? Yes ☐ No ☐		Number of Children:
Occupation:		Employer's Name:	
Emergency Contact:			Relationship to You:
Emergency Contact Phone:			
How did you hear about our practice?			

What are your primary reasons for seeking treatment today?

_____

_____

_____

Name_____ Date_____

Causes of Most Pain, Sickness and Disease

For your 1st visit-checkmark any causes you have experienced in last 6 months. For Re-exams-checkmark cause you are currently experiencing.

PHYSICAL	EMOTIONAL STRESSORS	NUTRITIONAL TOXICITIES/ DEFIECIENCIES	CHEMICAL TOXICITIES
__Computer work hours per day	___Work	Eat white sugar	__Alcohol
__Repetitive stress activities_____	___Home	___Eat white flour	__Vaccinations
__Over Exercise	___Negative thinker	___Drink coffee	__Toxic Cleaners
__Under Exercise	___Divorce	___Drink sodas	__Pesticides
__Poor Quality Sleep	___Death of a close family	___Eat trans fats	__Fertilizers
__Sprains/strains_____	___Job loss	___Eat fried foods	__Work Place Chemicals
__Concussions	___Diagnosed with disease	___Eat fast foods	__Shower/ Swim in Chlorine Water
__Car Accidents (please list below)	___Financial stress	___Overeating	__Substance Abuse
__Falls (please list below)	___Difficult childhood	___Stressed eating	__Prescription & Over the Counter Drugs (please list below)
__Sports injuries (please list below)	___Family issues/conflict	___Under eating	
__Broken bones (please list below)	___Hours watch T.V per day_____	___ Other_____	
__Surgeries (please list below)	___Guilt/ Remorse/ Regret		
__Stitches	Other_____		
__Other_____			

List all recent accidents, falls, & injuries within the last 6 months:

Date:	Describe:
1)_____	_____
2)_____	_____
3)_____	_____
4)_____	_____
5)_____	_____

List accidents, falls & injuries (physical traumas) BEFORE 6 months ago:

Date:	Describe:
1)_____	_____
2)_____	_____
3)_____	_____
4)_____	_____
5)_____	_____

List all hospitalizations, surgeries, broken bones, stiches etc:

Date:	Describe:
1)_____	_____
2)_____	_____
3)_____	_____
4)_____	_____
5)_____	_____

List all current prescribed medications:

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____
10)_____

List all current "over the counter" medications:

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____
10)_____

Wellness Actions to Prevent Most Pain, Sickness, and Disease

Please checkmark the wellness actions you are doing and fill in appropriate questions.

REST & RELAXATION	MIND, EMOTIONS & SPIRITUALITY	EXERCISE	Frequency / Duration
___ Engage in activities to Distress your body	___ Actively Think Positively Daily	___ Stretching	_____
___ Get 8 hours good quality sleep regularly	___ Express Gratitude Daily	___ Small motor movements activities	_____
___ Take breaks throughout the day	___ Pray	___ Weight train	_____
___ Use a special pillow	___ Meditate	___ Endurance train	_____
___ Use a special mattress	___ Journal	___ Wear orthotics	_____
___ Use black out curtains	___ Emotional Freedom Technique	___ Floss your teeth	_____
___ Cover all light sources including clocks	___ Emotional CPR	___ Other:_____	_____
___ Stop watching TV at least 2 hours before bed	___ Other:_____		_____
___ Turn off Computer at least 2 hours before bed			_____
___ Decrease lighting 2 hours before bedtime			_____
___ Other:_____			_____

NERVOUS SYSTEM & BODY WORK	Reason For Going	Date Of First & Last Visit	Results
___ Chiropractic	_____	_____	_____
___ Massage	_____	_____	_____
___ Physical Therapy	_____	_____	_____
___ Accupuncture	_____	_____	_____
___ Other:_____	_____	_____	_____

NUTRITION	Nutritional Supplements	Reason / Results	List Dietary Changes That Have Worked Well Or Poorly For You In The Past
___ Eat Vegetables Daily	1) _____	_____	1) _____
___ Eat Fruits Daily	2) _____	_____	2) _____
___ Eat Animal Protein Daily	3) _____	_____	3) _____
___ Drink bottled or filtered water daily	4) _____	_____	4) _____
___ Make and Drink Fresh Juices	5) _____	_____	5) _____
___ Avoid Trans Fats	6) _____	_____	6) _____
___ Avoid MSG	7) _____	_____	7) _____
___ Avoid Artificial Sugar	8) _____	_____	8) _____
___ Avoid Refined Flour	9) _____	_____	9) _____
___ Avoid Refined Sugar	10)_____	_____	10)_____

Name_____ Date_____ consistency taking supplements_____%

7 PILLARS OF HEALTH - SURVEY OF YOUR BODY'S SYSTEMS v3.1

For FIRST VISIT- Rate severity of symptoms below you have experienced in last 6 MONTHS from 0-10 (10 worst) or circle where appropriate

For RE-EXAMS- Rate severity symptoms below you are CURRENTLY experiencing from 0-10 (10 worst) or circle where appropriate

Neuro-hormonal/ Endocrine Pillar #1

Adrenals

Energy Low/ Variable/ Normal/ High
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Slow to Start in Morning
___ Energy Crash_____am/pm
___ Dizzy when stand quickly
___ Light Bothers Eyes
___ Weak Nails
___ Perspire easily or excessively
Orgasm Quality (poor/ fair/ good/ great)
Other_____

Pituitary

___ Sex Drive Flat/ Low/ Normal/ High
___ Menstrual Disorders
___ Splitting Headaches
Other_____

Thyroid

___ Tired/ Sluggish throughout day
___ Chills, Feel Cold hands, feet, body
___ Require Excessive Sleep
___ Increase in weight unexplained
___ Difficult infrequent bowel movements
___ Depression Lack of Motivation
___ Hair Loss and Thinning
___ Thinning of Outer Third of Eyebrow
___ Dryness of Scalp
___ Mental Sluggishness
___ Heart Palpitations-Skip/Flutter
___ Inward trembling
___ Increase pulse at rest
___ Insomnia-cannot sleep
___ Night Sweats
Other_____

Uterus (women only)

Last Menstrual Period_____
Length of Menses_____
Regular cycle
___ Irregular cycle
___ Early (less than 28 days)
___ Late (more than 28 days)
___ Skip cycle
___ Flow (heavy/ moderate/ light)
___ Cramps (mild/ mod/ severe)
___ Clotting/ Spotting
___ Headache side of head
Other_____

Ovaries (women only)

Sex Drive Flat/ Low/ Normal/ High
___ Low Abdominal Puffiness
___ Fluid Retention Face / Hands / Feet
___ mood swings/irritable/depression
___ Tired during cycle
___ Ovarian pain
___ Breast Tender around cycle
___ Acne around cycle (pre/mid/post)
___ Birth Control Pill / Patch
___ Menopausal Natural /Surgical
___ Hot Flashes
___ Facial Hair growth
___ Dark Nipple Hair
___ Hair growing up towards belly button
___ Skin Crawling
___ Breast discharge
___ Breasts shrinking
___ Breast Feeding
___ Breast Surgery
Other_____

Vagina (women only)

___ Burn
___ Itch
___ Dry
___ Discharge-clear white yellow green brown
___ Pain with Intercourse
Other_____

Testes (men only)

Sex Drive Flat/ Low/ Normal/ High
___ Decreased morning erections
___ Decreased fullness erections
___ Inability to concentrate
___ Episodes of depression
___ Decreased physical stamina
___ Sweating Attacks
___ More emotional than past
___ Unexplained weight gain
Other_____

Sleep

Quality (poor/fair/good/great)
____ Hours in bed
____ Hours asleep
___ Interrupted ___ per night
___ Awaken Suddenly (Jolt)
Other_____

Emotions

___ Stress
___ Sad
___ Grief
___ Depression
___ Moodiness
___ Frustrated
___ Irritable
___ Angry
___ Worrisome
___ Nervous
___ Anxiety
___ Panic
___ Cry
___ Fear
___ Shame
___ Guilt
Other_____

Brain

___ Forget Names
___ Forget Numbers
___ Forget Words
___ Forget Actions
___ Difficulty Focus/ Concentrating
Other_____

Exercise

Cardiovascular _____ times/ week
Weight Train _____times/per week
Other_____

Glycemic Management Pillar #2

Pancreas

___ Crave Sweets
___ Irritable when skip meals
___ Light headed skip meals
___ Eating relieves fatigue
___ Bouts of blurred vision
___ Fatigue after meals
___ Frequent Urination
___ Increased Thirst
___ Difficulty losing weight
Other_____

Appetite / Diet

Appetite (Low, Norm, High)
Eat Animal Protein_____/per day
Eat Starch (pasta/bread/potatoes/rice)
Eat Sweets (cakes, cookies, candy)
Eat Chocolate_____/per week
Eat Spicy Foods_____/per week
Eat Ice Cream_____/per week
Coffee _____cups/ week
Caffeinated Tea _____cups/week
Juice _____per week
Soda _____per week
Beer _____per week
Wine_____per week
Liquor _____per week
Avoid Artificial Sweeteners_____%
Avoid Trans Fats _____%
Avoid Food Allergens _____%
Special Diet?_____

Bioterrain/ Mineral Pillar #3

___ Twitching around eyes
___ Difficulty falling asleep
___ Restlessness
___ Don't Remember Dreams
___ Nails spots or weakness
___ Air Hunger/ frequent sighs
___ Cramps (legs/feet/arms/hands)
___ Aches (legs/feet/arms/hands)
___ Restless (legs/feet/arms/hands)
___ Frequent Thirst
___ Shallow rapid breathing
___ Poor muscle endurance
___ Swelling in ankles and wrists
___ Uterine cramps women
___ Urination leakage
Other_____

Inflammatory / Immune Pillar #4

Eyes

___ Burn / Red /Dry
___ Tears
___ Eye Film/ Crust in morning
___ Floaters
___ Stye
___ Itchy Eyes
___ Eye Ache
___ Vision blurry
___ Tired
___ Spots
___ Puffy
___ Dark Circles
Other_____

Ears

___ Ear Noise (Ring/Hiss/Pound)
___ Ear Plugged
___ Ear Popping
___ Ear Ache / Infections
___ Ears Itch internally
___ Ear Drainage
___ Hearing Loss
___ Excessive Ear Wax
___ Dizziness/ Vertigo
Other_____

Sinus

___ Frontal headache
___ Sinus dry
___ Sinus drain
___ Sinus stuffy or pressure
___ Sneeze frequent
___ Smell / Taste Loss
___ Post nasal drip
___ mucous: clear/white/yellow/green/brown
Other_____

Lungs

___ Chest Congestion
___ Pain on Breastbone
___ Shortness of Breath upon exertion
___ Frequent Sighs
___ Wheezing
___ Asthma
___ Emphysema
___ Bronchitis
Other_____

Mouth/ Throat/ Immune

___ Blisters
___ Canker Sore
___ Bad Breath
___ Dry Mouth
___ Bleeding gums
___ Receding gums
___ Teeth Health Problems
___ Swelling of Glands
___ Cough (dry/ productive)
___ Sore Throat
___ Hoarseness
___ Fever
___ Frequent Colds/ Flu
___ Environmental Allergies
___ Nail fungus (mild/mod/severe)
___ Nightmares
Other_____

Bladder

Urinate _____times per day-awake
Awake from sleep to urinate_____times
___ Urination urgency
___ Burning /Pain urination
___ Cloudy urine
___ Odor urine
___ Spasm urinate
___ Urinary Tract Infection
___ Kidney Pain or Infections
Other_____

Skin

___ Skin Rash
___ Acne
___ Itchy Skin
___ Cellulite
Other_____

Breasts (women only)

___ Breast fibrosis
___ Breast Lumps
Other_____

Prostate (Men only)

___ Urination difficulty
___ Frequent urination
___ Urination Burn / Achiness / Pain
___ Urination Dribbling /Emission/ Swelling
___ Pain inside of legs or heels
___ Leg twitching at night
___ Headache side of head
Other_____

Cardiovascular Pillar #5

___ Chest Tension/ Tight/ Pressure
___ Chest Heaviness
___ Chest Heart Pain
___ Heart Palpitations-Skip/Flutter
___ Heart Racing
___ Heart Slowing down
___ Constant Shortness of Breath
___ Sleep Apnea
___ Mitral Valve Prolapse
___ Murmur
___ Bruise easily
Other_____

Digestion Pillar #6

Stomach

___ Heartburn
___ Indigestion
___ Stomach Aches
___ Stomach Cramps
___ Nausea/ Queasy
___ Bloat after Eat
___ Gas/ Flatulence
___ Belching
___ Ulcer
___ Hiatal Hernia
Other_____

Liver/ Gallbladder

___ Headaches at base of skull
___ Greasy high fat foods cause distress
___ Difficulty losing weight
___ Dry or Itchy Skin
___ Patches skin look different
___ Yellow cast to eyes
___ Stool color clay colored
___ History of gallbladder attacks
___ Excessively foul smelling sweat
___ Hormonal imbalances
___ Difficulty Swallowing
___ Wake up between 11pm - 3am
Other_____

Hemorrhoids

___ Swollen/ Distended / Bloody Anus
___ Burning Anus
___ Itchy/ Stingy Anus
___ Achy Anus
Other_____

List Your Primary Concerns in order of importance to you:

1) _____
2) _____
3) _____

Bowels

Bowel Movements_____ Per day
Regular
___ Incomplete
___ Skip days _____ per (week/month)
___ Sluggish bowels every _____ days
___ Cramps in Abdomen
___ Taking Laxatives
___ Using Suppositories
___ Enemas
___ Colonics
___ Pain with Bowel Movements
___ Irritable Bowel Syndrome
___ Chrons
___ Colitis
Other_____

Fecal Consistency

Color feces light or dark _____
Normal
___ Soft
___ Hard
___ Pebbles
___ Dry
___ Ribbon-like
___ Bulky
___ Mucous
___ Diarrhea
___ Constipation
Other_____

Cellular Vitality Pillar #7

___ Fatigue constant
___ Dehydrated
___ Slow to Heal
___ Low Stamina
___ Sluggish Memory
___ Inability to achieve lean body
Other_____

PAIN/ STIFFNESS/ SWELLING/ ACHE/ NUMBNESS/ TINGLING

___ Head
___ Facial
___ Neck
___ Trapezius
___ Upper Back
___ Shoulders
___ Arms
___ Elbows
___ Wrist
___ Hand
___ Mid Back
___ Low Back
___ Sacral Iliac
___ Hips
___ Buttocks
___ Legs
___ Knees
___ Ankles
___ Feet
Other_____

For Doctor's Use

Luna Fingernails Rt 1 2 3 4 5 Lt 1 2 3 4 5
Splinter Hemorrhages
Ear Creases (Rt/ Lt) (mild/mod/severe)
Cherry Hemangioma
Frenulum Cyst
Color Tongue_____
Coated Tongue (mild/mod/severe)
Cracks in Tongue-midline/ all over
Swollen Tongue
Dark Veins under Tongue
Allergy Patches Tongue
Red Spots Tongue
Geographic Tongue
Height_____
Weight _____(+/-_____lbs.)
Overall(+/-_____) Desired Wt_____
Pulse_____BP:(_____/_____)
saliva pH_____ Urine pH_____
Allergies_____
Current Meds:_____

NUTRITION CONSULTING INFORMED CONSENT

I hereby request and consent to nutritional care/consulting on me (or on the client named below, for whom I am legally responsible) provided by Chronic Conditions Center of Greensboro and staff.

I understand and am informed that the nutrition consultations may not be made by medical physicians and do not dispense medical advice, diagnose illness or disease, offer prescription drugs, surgery, or other conventional treatments.

I understand and am informed that the nutrition consultations offer nutritional evaluations, nutritional supplementation, and lifestyle consultation along with various methods of testing. I further understand and am informed that the recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only provided by the health practitioner and/or his/her staff pertain to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.

I understand and am informed that methods of nutritional evaluation or testing made available to me are not intended to diagnose disease. Rather, these assessment tests are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor my progress in achieving my goals. I further understand that any nutritional recommendations are supportive in nature allowing the body to return to improved health. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment. Products are only refundable if they are unopened and in original condition, including not past their expiration date.

I understand and am informed that the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that have been recommended are traditionally considered safe in the practice of nutrition, however, some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I understand that some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner and/or his/her staff if I am or become pregnant.

I will also inform the health practitioner and/or his/her staff if I experience any gastrointestinal upset (including but not limited to nausea, gas, stomachache, vomiting), allergic reactions (including but not limited to hives, rashes, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients recommended by the health practitioner and/or his/her staff.

I have had an opportunity to ask questions about its content, and by signing below I agree to the above-named services. I intend this consent to cover the entire course of nutritional care/consulting.

I, _____ have read, or have had read to me, the above consent.
(Print Name)

_____ _____
(Signature) *(Date)*

Consent to evaluate and treat a minor child:
I, _____being the parent or legal guardian of _____ have read and fully understand the above consent and hereby grant permission for my child to receive care.

_____ _____
(Signature) *(Date)*

CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I, _____have read and fully understand the above statements.
(Print Name)

_____ _____
(Signature) *(Date)*

Consent to evaluate and adjust a minor child:
I, _____being the parent or legal guardian of _____ have read and fully understand the above statements and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Doctor's Signature) *(Date)*