CHRONIC CONDITIONS
CENTER OF GREENSBORO

Welcome to Chronic Conditions Center of Greensboro! As you embark on your journey in our clinic, there are a few things we want you to know. First of all, we wish to have a maximum positive impact on the life of every patient that walks through our doors. Your new patient exam will begin this process so that we may evaluate if you are a candidate for care in our office. Here are our goals of doing an initial exam and consultation:

1. To do the appropriate testing on each patient in order to find the root cause of their condition. Each person is treated as an individual.
2. To address your health challenges and return you to the most optimal state of health possible.
3. If accepted as a patient, to prevent future degeneration of your health.
4. To enhance, extend, and add massive quality to your life.

Your New Patient Appointment is scheduled for:

AM / PM

For your initial exam, DO NOT forget the following:

* Wear or bring shorts and t-shirt

* All paperwork filled out completely

* Any recent blood work (within the last year)

* Recent x-rays or MRIs

403 Parkway, Suite A • Greensboro, NC 2401 • Phone: (336) 285-7077
Dr. Darcy Ward, DC, BCIM
www.ConditionsCenter.com

CHRONIC CONDITIONS CENTER
CONFIDENTIAL PATIENT INFORMATION
(Please Print)

Date: _____ E-mail Address_____
Full Name: _____
Name of Wife, Husband, or Guardian: _____
Address: _____
City _____ State _____ Zip Code _____
Telephone Number ( ) _____ Cell Phone Number ( ) _____
Male _____Female _____
Birth Date: _____ Age _____ Currently Pregnant? _____
Marital Status: S ____ M____D____W____ Student: No_____ Part Time ____ Full Time_____
Occupation: _____
Employer's Name / Phone #: _____
Spouse's Occupation/Employer _____
Name and Phone # of Emergency Contact: _____
How did you hear about our office? _____

List Chiropractors you have seen before:

1. Name: _____ When Visited: _____
2. Name: _____ When Visited: _____

List Medical Doctors consulted within the past year:

1. Name: _____ Reason for visit? _____
2. Name: _____ Reason for visit? _____

Please list all your reasons for visiting our office:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List ***ALL*** medications you take. (Prescriptions and over-the-counter- use additional pages if needed)

Drug name:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ***ALL*** vitamins you take. (Use additional pages if needed)

Name of Supplements:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ***ALL*** previous hospitalizations, surgeries, accidents, fractures and illnesses (Use additional pages)
(Example: **All past** Auto, Sports, Work, Home related.)

1. Type _____ When _____ Hospitalized? Yes _____ No ____
2. Type _____ When _____ Hospitalized? Yes _____ No ____
3. Type _____ When _____ Hospitalized? Yes _____ No ____
4. Type _____ When _____ Hospitalized? Yes _____ No ____

Patient Name: _____

Check **ALL** "body signals" (symptoms/ pain) you may have had or do have now:

___ ADD/ ADHD	___ Depression	___ Hepatitis	___ Miscarriage
___ Alcoholism	___ Diabetes	___ High Blood Pressure	___ Multiple Sclerosis
___ Allergy	___ Diarrhea	___ High Cholesterol	___ Neck Pain
___ Alzheimer's	___ Eczema	___ High Blood Sugar	___ Parkinson's Disease
___ Anemia	___ Emphysema	___ HIV/ AIDS	___ Pneumonia
___ Appendicitis	___ Epilepsy/seizures	___ Irregular Periods/Cramps	___Raynaud's
___ Asthma	___ Fibromyalgia	___ Irritable Bowel	___ Rheumatoid Arthritis
___ Arthritis	___ Gall Bladder	___ Kidney infections/stones	___ Ringing in Ears
___ Back pain	___ Goiter	___ Low Blood Pressure	___ Sinus infections
___ Cancer	___ Gout	___ Low Blood Sugar	___ Stroke
___ Celiac/ Gluten Dis.	___ Headaches	___ Lyme Disease	___ Thyroid Problems
___ Chronic Fatigue	___ Heart Attack	___ Lupus	___ Ulcers
___ Constipation	___ Heart Disease	___ Migraine	___ Vertigo/dizziness

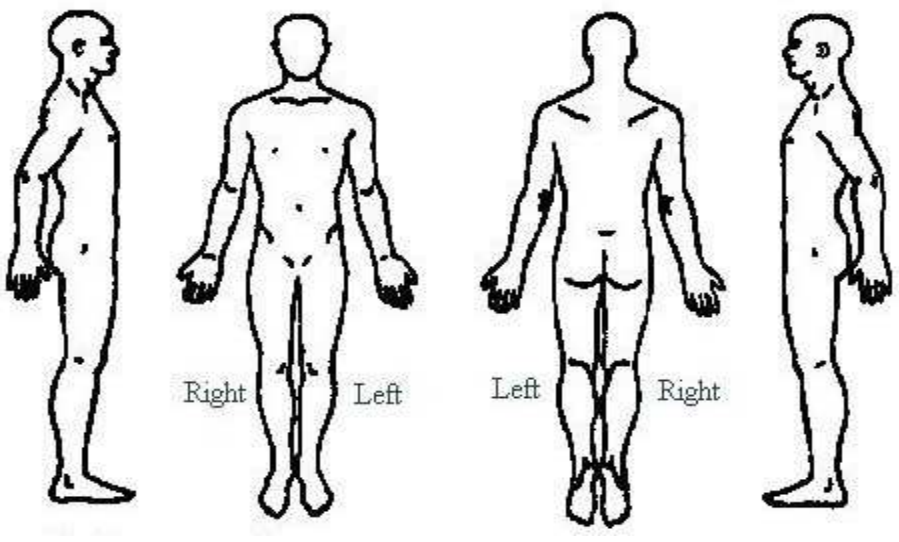
Please check all of the following conditions your family has experienced:

Mother:	___Alzheimer's	___Cancer	___Diabetes	___Heart Disease	___Parkinson's	___MS	___Stroke
Father:	___Alzheimer's	___Cancer	___Diabetes	___Heart Disease	___Parkinson's	___MS	___Stroke
GMother(M):	___Alzheimer's	___Cancer	___Diabetes	___Heart Disease	___Parkinson's	___MS	___Stroke
GFather(M):	___Alzheimer's	___Cancer	___Diabetes	___Heart Disease	___Parkinson's	___MS	___Stroke
GMother(P):	___Alzheimer's	___Cancer	___Diabetes	___Heart Disease	___Parkinson's	___MS	___Stroke
GFather (P):	___Alzheimer's	___Cancer	___Diabetes	___Heart Disease	___Parkinson's	___MS	___Stroke
Sisters:	___Alzheimer's	___Cancer	___Diabetes	___Heart Disease	___Parkinson's	___MS	___Stroke
Brothers:	___Alzheimer's	___Cancer	___Diabetes	___Heart Disease	___Parkinson's	___MS	___Stroke

List any other health conditions that you or your family have had that are not listed: _____
_____

Do you consume any of the following? (Leave blank what doesn't apply)
Tobacco products (packs/day): ____How many years?___ Alcohol drinks/day: ___ How many years? ____
Coffee/Tea cups/day: ____Regular or decaf:_____ Soft drinks # day:____ Regular or diet?_____
Do you use artificial sweeteners? ___ Yes___ No If yes please list_____
Level of exercise? _____ None _____ Moderate (days per week) _____ Strenuous (days per week)
Have you experienced any <u>unexplained or rapid</u> weight changes in the last six months? __Yes __ No ____ lbs

Please mark off the areas of your complaint on the diagram below. Use the following symbols:
<u>P= pain, N= numbness, T= tingling, B= burning, C= cramping</u>



CHRONIC CONDITIONS CENTER OF GREENSBORO
NEUROLOGICAL ASSESMENT FORM

NAME: _____ **DATE: _____**

Are you left or right handed? _____ Right Left
Have you had a head injury? _____ YES NO
Do you currently experience or have a past history of vertigo or balance disorders? _____ YES NO
Do you have any ringing or pressure in the ears? _____ YES NO
Do you experience nausea? _____ YES NO
Do you find that your balance is getting worse? _____ YES NO
Do you have difficulties walking down stairs? _____ YES NO
Do you have difficulty with math problems, or remembering numbers? _____ YES NO
Do you find yourself searching for words frequently when you speak? _____ YES NO
Have you noticed your ability to concentrate is getting worse? _____ YES NO
Do you get lost often or have a hard time with directions? _____ YES NO
Do quick flashes of light on TV or loud noises bother you? _____ YES NO
Do you feel like you need to wear sunglasses outside? _____ YES NO
Has your handwriting changed in recent years? _____YES NO
Do you have a hard time swallowing? _____ YES NO
Do you gag easily? _____ YES NO
Do you experience blurriness in your vision or double vision? (**CIRCLE**) _____ YES NO
Do you have any changes in smell or smell foul things that are not present? _____ YES NO
Do you have any difficulty with taste or taste things differently than what you are eating? _YES NO
Noticed clumsiness in hand coordination? Which hand? Right/ Left (**CIRCLE**) _____YES NO
Do you have difficulty with short-term memory? _____YES NO
Have you been told or noticed any memory loss of past events? _____YES NO
Noticed uneven sweating or temperature on one side of your body? _____YES NO
Do you have any tightness, weakness or instability in your back or neck? (**CIRCLE**) ____YES NO
Do you have tightness, or feelings of weakness in your hands or legs? (**CIRCLE**) _____YES NO
Do you ever have any numbness or tingling in your hands, legs, or face? (**CIRCLE**) ____YES NO
Do you have any difficulty with falling asleep or staying asleep? _____YES NO
Do you get motion sickness easily (car sick or sea sick)? _____ YES NO
Do you ever experience flashes of light in your visual field? _____ YES NO
Do you ever experience dry eyes or mouth? (**CIRCLE**) _____ YES NO
Do you ever experience increase tearing or salivation? (**CIRCLE**) _____ YES NO
Do you ever have slurred speech? _____ YES NO
Noticed any drooping of your eyelids or facial muscles? (**CIRCLE**) _____ YES NO
Do you ever notice increased heart rate (tachycardia) or pulse during the day? _____YES NO
Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)? __ YES NO
Do you experience Déjà vu? _____ YES NO
Does driving cause you fatigue, headaches, or other symptoms? (**CIRCLE**) _____YES NO
Does working on a computer cause you fatigue, headaches or other symptoms? _____YES NO
Have you lost your interest in hobbies and functions that you used to enjoy? _____ YES NO
Do you have a hard time motivating yourself to engage in activities? _____ YES NO
Do you ever have fluttering of the eye or noticed you are blinking frequently? _____YES NO
Do you have difficulty distinguishing right and left? _____ YES NO

Patient Signature: _____ Date: _____

Patient Name: _____

Complaint History

Complaint 1: _____

When did your complaint first begin? _____ Have you ever experienced this complaint before? _____

What makes your problem better? _____

What makes your problem worse? _____

Describe the type of pain/ symptom you experience? _____

_____

Does your problem travel into any other part of your body? Where? _____

_____

Where exactly is the complaint area? _____

Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? _____

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? _____

Complaint 2: _____

When did your complaint first begin? _____ Have you ever experienced this complaint before? _____

What makes your problem better? _____

What makes your problem worse? _____

Describe the type of pain/ symptom you experience? _____

_____

Does your problem travel into any other part of your body? Where? _____

_____

Where exactly is the complaint area? _____

Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? _____

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? _____

Complaint 3: _____

When did your complaint first begin? _____ Have you ever experienced this complaint before? _____

What makes your problem better? _____

What makes your problem worse? _____

Describe the type of pain/ symptom you experience? _____

_____

Does your problem travel into any other part of your body? Where? _____

_____

Where exactly is the complaint area? _____

Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? _____

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? _____

The Neck Disability

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1- PAIN INTENSITY

I have no pain at the moment
The pain is very mild at the moment
The pain is moderate at the moment
The pain is fairly severe at the moment
The pain is very severe at the moment
The pain is the worst imaginable at the moment

SECTION 2- PERSONAL CARE (Washing, Dressing, etc.)

I can look after myself normally, without causing extra pain I can look after myself normally, but it causes extra pain
It is painful to look after myself and I am slow and careful I need some help, but manage most of my personal care I need help every day in most aspects of my life
I do not get dressed: I was with difficulty and stay in bed

SECTION 3- LIFTING

I can lift heavy weights without extra pain
I can lift heavy weights, but it gives extra pain
Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example- on table
Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
I can lift very light weights
I cannot lift or carry anything at all

SECTION 4- READING

I can read as much as I want to, with no pain in my neck
I can read as much as I want to, with slight pain in my neck
I can read as much as I want to, with moderate pain in my neck
I can read as much as I want to, because of moderate pain in my neck
I can hardly read at all, because severe pain in my neck I cannot read at all

SECTION 5- HEADACHES

I have no headaches at all
I have slight headaches that come frequently I have moderate headaches that come infrequently I have moderate headaches that come frequently I have severe headaches that come frequently I have headaches almost all the time

SECTION 6- CONCENTRATION

I can concentrate fully when I want to without difficulty
I can concentrate fully when I want to with slight difficulty
I have a fair degree of difficulty in concentrating when I want to I have a lot of difficulty in concentrating when I want to
I have a great deal of difficulty in concentrating when I want to I cannot concentrate at all

SECTION 7- WORK

I can do as much work as I want to
I can do my usual work but no more
I can do most of my usual work; but no more I cannot do my usual work
I can hardly do any work at all I can't do any work at all

SECTION 8- DRIVING

I can drive my car without any neck pain
I can drive my car as long as I want, with slight neck pain
I can drive my car as long as I want, with moderate neck pain
I can't drive my car as long as I want, because of moderate neck pain
I can't drive at all, because of severe neck pain I can't drive my car at all

SECTION 9- SLEEPING

I have no trouble sleeping
My sleep is slightly disturbed (less than 1 hr sleepless)
My sleep is slightly disturbed (1-2 hrs sleepless)
My sleep is moderately disturbed (2-3 hrs sleepless)
My sleep is greatly disturbed (3-5 hrs sleepless)
My sleep is completely disturbed (5-7 hrs sleepless)

SECTION 10- RECREATION

I am able to engage in all my recreation activities, with no neck pain at all
I am able to engage in all my recreation activities, with some neck pain
I am able to engage in most, but not all, of my usual recreational activities because of neck pain
I am able to engage in few of my recreation activities, because of my neck pain

PRINTED NAME DATE

PATIENT SIGNATURE

The Revised Oswestry Disability Index (for low back pain/ dysfunction)

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1- PAIN INTENSITY

The pain comes and goes and is very mild.
The pain is mild and does not vary much.
The pain comes and goes and is moderate.
The pain is moderate and does not vary much.
The pain comes and goes and is very severe.
The pain is severe and does not vary much.

SECTION 2- PERSONAL CARE (Washing, Dressing, etc.)

I would not have to change my way of washing or dressing in order to avoid pain.
I do not normally change my way of washing, or dressing even though it causes some pain.
Washing and dressing increases the pain, but I manage not to change my way of doing it.
Because of the pain, I am unable to do some washing and dressing without help.
Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3- LIFTING

I can lift heavy weights without extra pain.
I can lift heavy weights, but it causes extra pain.
Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on the table)
Pain prevents me from lifting heavy objects off the floor.
Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
I can only lift very light weights at the most.

SECTION 4- WALKING

I have no pain on walking.
I have some pain on walking, but it does not increase with distance.
I cannot walk more than one-mile without increasing pain. I cannot walk more than ½ mile without increasing pain. I cannot walk more than ¼ mile without increasing pain. I cannot walk at all without increasing pain.

SECTION 5- SITTING

I can sit in any chair as long as I like.
I can only sit in my favorite chair as long as I like.
Pain prevents me from sitting more than 1 hour. Pain prevents me from sitting more than ½ hour. Pain prevents me from sitting more than 10 min. I avoid sitting because of pain right away.

SECTION 6- STANDING

I can stand as long as I want without pain.
I have some pain on standing, but it does not increase with time.
I cannot stand for longer than 1 hour without increasing pain.
I cannot stand for longer than ½ hour without increasing pain.
I cannot stand for longer than 10 minutes increasing pain. I avoid standing because there is pain right away.

SECTION 7- SLEEPING

I get no pain in bed.
I get pain in bed, but it does not prevent me from sleeping well.
Because of pain, my normal night's sleep is reduced by less than ¼
Because of pain, my normal nights sleep is reduced by less than ½
Because of my pain, my normal night's sleep is reduced by less than ¾
Pain prevents me from sleeping at all.

SECTION 8- SOCIAL LIFE

My social life is normal and gives no pain.
My social life is normal, but increases the degree of pain.
Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
Pain has restricted my social life and I do not go out very often.
Pain has restricted my social life to my home.
I have hardly any social life because of the pain.

SECTION 9- TRAVELIING

I get no pain while traveling.
I get some pain while traveling, but none of my usual forms of travel makes it any worse.
I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
I get extra pain while traveling, which compels me to seek alternative forms of travel.
Pain restricts all forms of travel.
Pain prevents all forms of travel except that done lying down.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

Metabolic Assessment Form

Name: _____ **Age**: _____ **Sex**: _____ **Date**: _____

PART I

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II **Please circle the appropriate number "0-3" on all questions below.**
0 as the least/never to 3 as the most/always

Category I				
Feeling that bowels do not empty completely Lower	0	1	2	3
abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3
Category III				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating Heartburn	0	1	2	3
when lying down or bending forward Temporary	0	1	2	3
relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate citrus, peppers, alcohol, and caffeine	0	1	2	3
Category IV				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous-like, Greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/ or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes		No	
Category VI				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category VII				
Fatigue after meals	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VIII				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X

Tired, sluggish	0	1	2	3
Feel cool- hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or Excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Males only)

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you premenopausal	Yes		No	
Alternating menstrual cycle lengths	Yes		No	
Extended menstrual cycle, greater than 24 days	Yes		No	
Shortened menses, less than every 24 days	Yes		No	
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/ thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal?	_____			
Since menopause, do you ever have uterine bleeding?	Yes		No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consumer per day? _____

How many times a week do you work out? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____ How many times a week do you eat raw nuts or seeds? _____

List three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____ Do you smoke? _____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

CHRONIC CONDITIONS CENTER OF GREENSBORO

Name: _____ Date: _____

Please take several minutes to answer these questions so Dr. Ward can help you get better faster.

(Please circle as many that apply)

1. How have you taken care of your health in the past?

a. Medications
b. Emergency Room
c. Routine Medical
d. Exercise
e. Nutrition/Diet
f. Holistic Care
g. Vitamins
h. Chiropractic
i. Other (please specify)

2. How did the previous method(s) work out for you?

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

3. How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self---esteem
f. Sleep
g. Time
h. Finances
i. Freedom

5. Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
f. Fibromyalgia
g. Depression
h. Chronic fatigue
i. Need surgery

5. How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

_____
_____
_____
_____

6. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

_____
_____
_____
_____

7. What are you most concerned with regarding your problem?

_____
_____
_____
_____

8. Where do you picture yourself being in the next 1---3 years if this problem is not taken care of? Please be specific:

_____
_____
_____
_____

9. What would be different/better without this problem? Please be specific:

_____
_____
_____
_____
_____

10. What do you desire most to get from working with us?

_____
_____
_____
_____

11. On a scale of 1 to 10 (with 10 being the best) what is your level of commitment to regaining your health?

_____
_____
_____
_____