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 and thoroughly**

* Any recent blood work (within the last year)

* Recent x-rays or MRIs

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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

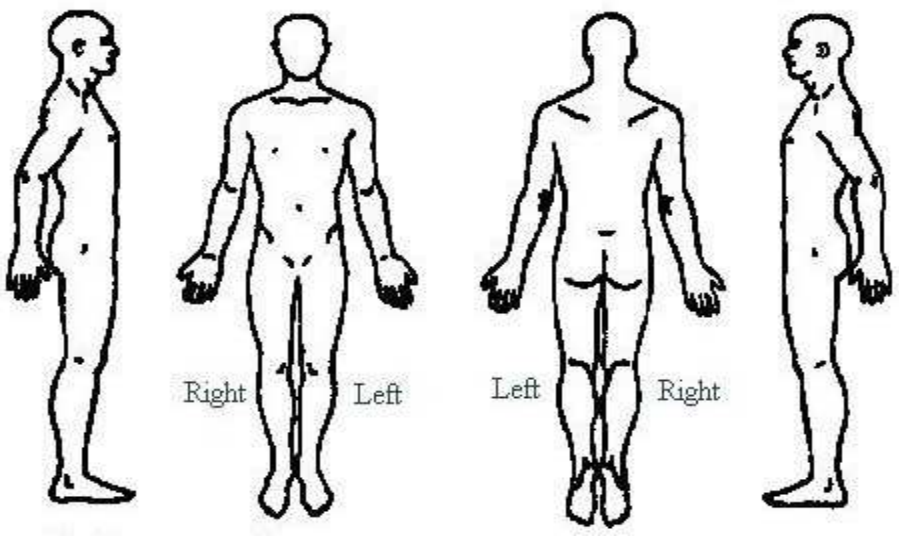
Please check all of the following conditions your family has experienced:

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>



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? _____

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. Injections
j. 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?

_____
_____
_____
_____