CHRONIC CONDITIONS
Center of Greensboro

Your Wellness History—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:	**Date:**
Address:	
City:	**State:** **Zip Code:**
Cell phone:	**Home phone:**
Email address:	
Date of birth:	**Age:** **Male** ☐ **Female** ☐
No. of children:	**Pregnant?** **Yes** ☐ **No** ☐
Height:	**Weight:**
Marital status: **M** **S** **W** **D**	**Spouse/guardian name:**
Your Occupation:	
Your Employer's name:	**Work phone:**
Spouse's Occupation/Employer:	
Emergency Contact:	**Phone:**
Relationship to you:	

Whom may we thank for referring you, or how did you hear about us? _____

List your ***first*** Complaint: _____

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.)? _____

Is there a time of the day when your pain is WORSE? _____

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

List your ***second*** Complaint: _____

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.)? _____

Is there a time of the day when your pain is WORSE? _____

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

List your ***third*** Complaint: _____

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.)? _____

Is there a time of the day when your pain is WORSE? _____

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

Lifestyle factors over a long period of time often affect our health in ways that we may not even be aware of. Please take special care to answer the following questions carefully. Thank you.

Diet -------- Please circle any dietary selection that is appropriate for you, and grade according to the following scale:
D - Consume this daily | FD - Consume this a few times per day | W - Consume this weekly | FW - Consume this a few times per week | FM - Consume a few times per month (less than weekly) | M - Consume this monthly | O - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee/black tea	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables	Fast Food	Candy	Bread

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 ____
5. Type _____ When _____ Hospitalized? Yes _____ No ____
6. 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_____
Do you exercise (Type)? _____ 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

Do you have, or have you had any of the following:

Stomach Disorder ___No ___Yes Hiatal Hernia _____ Heartburn ____ Stomach Stapled____ Other_____
Heart Disease: ____No ____ Yes If yes, describe _____
High Blood Pressure: ___No ___Yes Cancer: Where? _____
High Cholesterol/Triglycerides_____
Diabetes: ___No ___Yes How Long _____ If yes, how is it controlled? _____
Thyroid Disease: ___No ___Yes If yes, describe:_____

Have you had any of the following diseases: (Circle all that apply) Anemia Rheumatic Fever Epilepsy Influenza
Appendicitis Pneumonia Mumps Pleurisy Measles Whooping Cough Polio Chicken Pox Mental Disorder

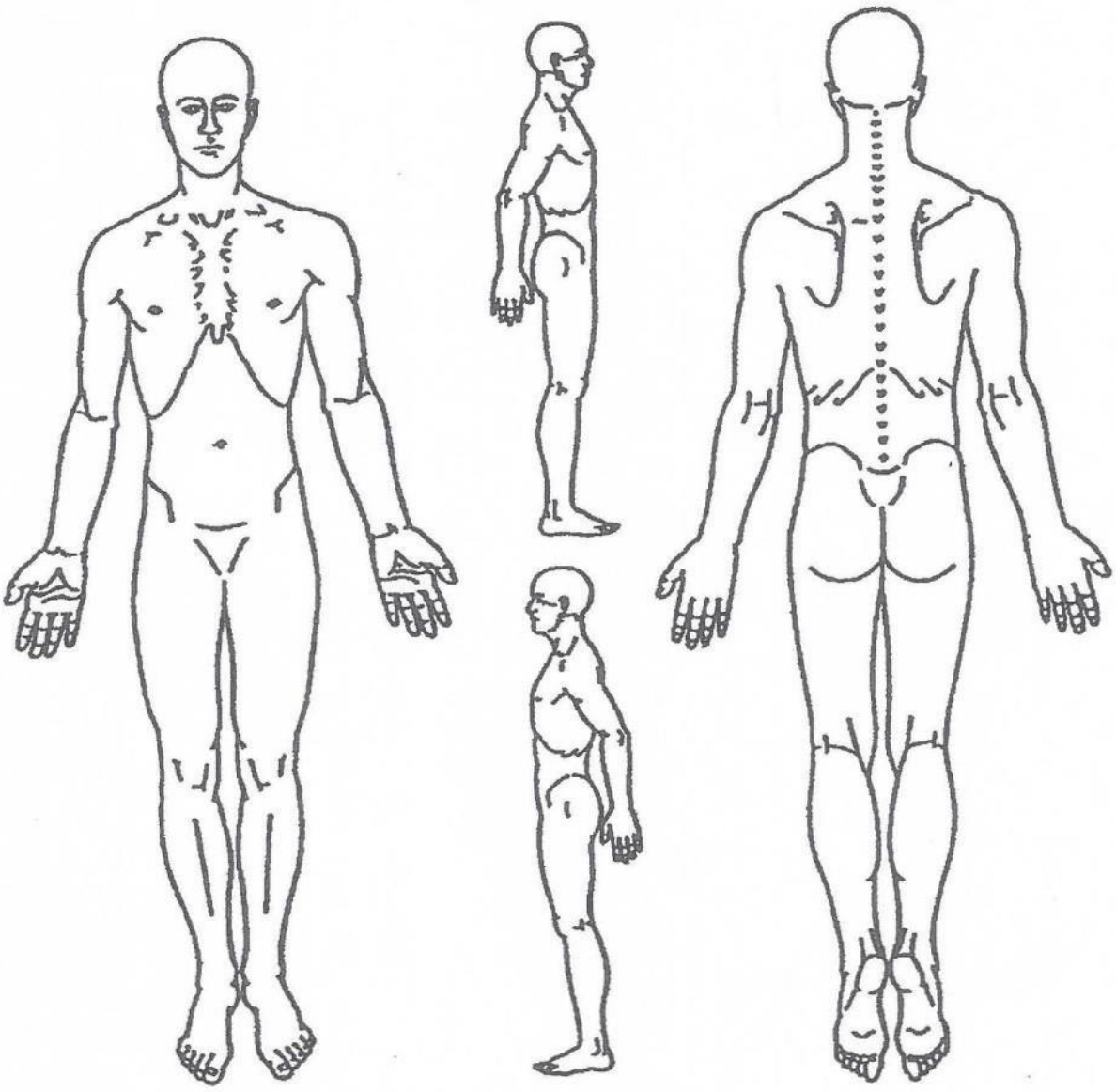
What other health or medical challenges/issues do you have: _____

Have you had any of the following organs/glands removed: Gallbladder Uterus or Ovaries Appendix Thyroid
Tonsils & Adenoids
Any other body part removed: _____

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

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Name: _____ Date of Birth: _____

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
e. Fibromyalgia
f. Depression
g. Chronic fatigue
h. Need surgery

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

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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

_____
_____

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

_____
_____
_____

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

_____
_____

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

_____
_____

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OFFICE POLICIES

******Please read all of these thoroughly before signing******

1. PAYMENT IS DUE IN FULL WHEN SERVICES ARE RENDERED. PRE-PAYMENTS AND PAYMENT PLANS MAY BE ACCEPTED ON A CASE-BY-CASE BASIS. A general schedule of services and fees are available by inquiring at the front desk. Payments can be made by cash, check, debit card, credit card, health savings, or flex spending accounts.

2. In the event that a patient's account is delinquent, an overdue notice will be sent his/her address on file. If payment is not received within 30 days of the notice date, a 1.5% per month service charge will be incurred until paid in full.

3. There will be an additional $25 fee for returned or NSF checks.

4. This office is not in network with any insurance company, nor will we submit any insurance claim for you. You may ask for a Superbill to submit to your insurance for re-imbursement. If you have an HSA account, most often you may use your flex spending card to pay for your services.

5. It is not this office's obligation to enter into a dispute with an insurance company concerning payment.

6. If 6 months or more lapse between a patient's treatments, the next appointment scheduled will automatically be a re-examination, which incurs an additional fee.

7. Nutrition consultations, exercise consults or supplement charges are due at the time of service. These are cash services, not covered by any insurance or third-party payers.

8. Laboratory testing (varies by company) may or may not be covered by your insurance.

9. Medicare covers spinal adjustments only in an acute injury and does not cover any exams, x-rays, re-exams, modalities, extremity adjustments, supports or supplements. If you receive any of these non-covered services or supplements, it is your responsibility to pay the complete cost at the time received. Medicare also does not cover Maintenance or Wellness care. If you choose these services, these are paid out of pocket at the Medicare rate.

Patient's Printed Name: _____ Date: _____

Signature: _____

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Informed Consent for Examination & Treatment

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, supplements, therapies, diagnostic testing as order by my provider or any healthcare professional assigned to my care, and I acknowledge and consent to the following:

- During the course of my care and treatment, I understand that various types of examinations, tests, therapies, diagnostic or treatment procedures may be necessary. These procedures may be performed by chiropractic physicians, physician assistants, nurse practitioners, chiropractic assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask for additional information. I also understand staff may ask me to sign additional Informed Consent documents relating to specific procedures.
- No guarantee of results: CCCG physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, therapy, procedure or medical care.
- I understand that I can change my mind regarding the procedure or treatment. If I do, I must tell the person or the team doing the treatment or procedure before they start.
- I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as any other information provided by me, my loved ones present at the examination/appointment, or others that I have authorized to discuss my healthcare information on my PHI document, in determining whether or not to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.
- Our office routinely makes video and audio recordings for security, quality assurance, and training purposes. Recording devices are placed throughout the office. By entering our office, you are consenting to be video recorded, and audio recorded. I hereby give my permission to be recorded and for those recordings to be used for security, quality assurance, and training purposes only.
- I understand the clinic, as required by law, must report certain diseases to local and state agencies.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete. A copy of this document may be utilized the same as the original.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

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Patient Missed Appointment Policy

It is our wish that each and every one of our patients receives the very best care and service possible. Your Treatment Program consists of a specific series of treatments given over a pre-planned time span. If you cannot follow this plan, then you will not receive the desired results. If we did not insist that you meet all of your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your scheduled appointments. Arrange the activities in your life so that this can occur.

2. Our office strives to run on time as much as possible. If you are more than 5 minutes late for an appointment, you may be asked to reschedule.

3. If you become ill, there are instances where we want you to come in, because your treatment will help you recover, so please ask the front desk about your illness and if you should come in for treatment.

4. If you are unable to make it due to an emergency, please call and let us know so that we can reschedule your appointment.

5. With the exception of unexpected emergencies, please call and let us know at least 24 hours in advance to change an appointment.

6. If you choose to not finish your entire treatment regimen for the day, they will be counted as completed. The only exception that is made is in the event that the office is not able to accommodate your therapies in an adequate time frame during the scheduled therapy time.

7. Service charges for missing an appointment or cancelling without 24-hour notice are as follows:

15-minute appointment $45
30-minute appointment $60

Treatment Packages:
1 warning and then 1 treatment will be deducted per missed or late cancel appointment

*Note: Text reminders are made the day before each patient's appointment. These texts are a courtesy service, meant to remind patients of their appointment times. However, failure to receive a confirmation text does NOT validate a missed appointment.

I have read and understand the above policies.

Patient's Name: _____ Date: _____

Signature: _____

Witness: _____ Date: _____

CHRONIC CONDITIONS
Center of Greensboro

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Chronic Conditions Center of Greensboro or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the complete Notice of Privacy Practices for more description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you, and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Our Privacy Pledge
We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- Your health care practitioner and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information at any time.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office.
- Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

By my signature below I give my permission to use and disclose my health information in the ways listed above.

Patient's Name (PRINT): _____ Date: _____

Signature: _____

Witness Signature: _____ Date: _____

CHRONIC CONDITIONS
Center of Greensboro

PHI (Protected Health Information) Disclosure Agreement

Patient Name: _____ Date of Birth: _____

Chronic Conditions Center is authorized to release my protected health information in the following manner and/or the selected person(s):

Please check all ways you would like to receive information:

Email	Text	Voice Mail

Please List any individuals that you authorize your PHI to be shared with:

_____ _____ _____

Name Number Relation

_____ _____ _____

Name Number Relation

I authorize the above individuals to receive the following types of information:

	Medical	Financial
Patient Rights:		

-I have the right to revoke this authorization at any time

-Revocation is not effective in cases where the information has already been disclosed

-Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law

_____ _____

Signature of Patient Date