231 N. Spring St. Suite A, Greensboro, NC 27401
(336) 285-7077

Welcome!

The following is information regarding your first visit at Center for Chiropractic & Wellness. 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

The fee for your initial visit will depend on your insurance verification. Our office accepts Blue Cross Blue Shield, Cigna, and Medcost. If you do not have health insurance your first initial visit is $70 for your new patient exam and your second visit is $60 for your report of findings and treatment. Please note that most nutrition visits are not covered by insurance. Follow up chiropractic visits are $60 and follow up nutrition visits are $45. 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.

Best Wishes,
Center for Chiropractic & Wellness Team

Health and Wellness – Intake Form

Welcome to Center for Chiropractic & Wellness. 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

- __ Computer work hours per day
- __ Repetitive stress activities_____
- __ Over Exercise
- __ Under Exercise
- __ Poor Quality Sleep
- __ Sprains/strains______________
- __ Concussions
- __ Car Accidents (please list below)
- __ Falls (please list below)
- __ Sports injuries (please list below)
- __ Broken bones (please list below)
- __ Surgeries (please list below)
- __ Stitches
- __ Other_________________________

EMOTIONAL STRESSORS

- __ Work
- __ Home
- __ Negative thinker
- __ Divorce
- __ Death of a close family
- __ Job loss
- __ Diagnosed with disease
- __ Financial stress
- __ Difficult childhood
- __ Family issues/conflict
- __ Hours watch T.V per day_____
- __ Guilt/ Remorse/ Regret
- Other____________________

NUTRITIONAL TOXICITIES/ DEFIECIENCIES

- Eat white sugar
- __ Eat white flour
- __ Drink coffee
- __ Drink sodas
- __ Eat trans fats
- __ Eat fried foods
- __ Eat fast foods
- __ Overeating
- __ Stressed eating
- __ Under eating
- Other________________________

CHEMICAL TOXICITIES

- __ Alcohol
- __ Vaccinations
- __ Toxic Cleaners
- __ Pesticides
- __ Fertilizers
- __ Work Place Chemicals
- __ Shower/ Swim in Chlorine Water
- __ Substance Abuse
- __ Prescription & Over the Counter Drugs (please list belo\

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

- __ Engage in activities to Distress your body
- __ Get 8 hours good quality sleep regularly
- __ Take breaks throughout the day
- __ Use a special pillow
- __ Use a special mattress
- __ Use black out curtains
- __ Cover all light sources including clocks
- __ Stop watching TV at least 2 hours before bed
- __ Turn off Computer at least 2 hours before bed
- __ Decrease lighting 2 hours before bedtime
- __ Other:______________

MIND, EMOTIONS & SPIRITUALITY

- __ Actively Think Positively Daily
- __ Express Gratitude Daily
- __ Pray
- __ Meditate
- __ Journal
- __ Emotional Freedom Technique
- __ Emotional CPR
- __ Other:______________

EXERCISE

- __ Stretching
- __ Small motor movements activities
- __ Weight train
- __ Endurance train
- __ Wear orthotics
- __ Floss your teeth
- Other:______________

Frequency / Duration

____

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:_______________

Nutritec Software Symptom Survey

NAME: ____________________ DATE: ___________

Phone: ___________________ E-mail: ___________

Fax: __________________ DOB: ____/____/____

Sex: ☐ Male ☐ Female Tissue Calcium:_______

Height: ______________ Weight: ____________

Blood Pressure: Pulse:____

Sitting:________ Laying:_______ Standing:________

INSTRTIONS: Completely black out one of the three circles: 1-mild, 2-moderate, 3-severe

● ○ ○ MILD symptoms (once or twice last 6 months)
○ ● ○ MODERATE symptoms (once or twice last month)
○ ○ ● SEVERE symptoms (Chronic, once or twice last week)
○ ○ ○ Leave circles BLANK if they do not apply to you!

1 2 3 ----------- GROUP 1 ----------

1 ○ ○ ○ Acid foods upset
2 ○ ○ ○ Feel chilled often
3 ○ ○ ○ "Lump" in throat
4 ○ ○ ○ Dry mouth-eyes-nose
5 ○ ○ ○ Pulse speeds after meals
6 ○ ○ ○ Keyed up; unable to feel calm
7 ○ ○ ○ Cuts heal slowly
8 ○ ○ ○ Gag easily
9 ○ ○ ○ Unable to relax; startles easily
10 ○ ○ ○ Extremities cold and/or clammy
11 ○ ○ ○ Strong light irritates
12 ○ ○ ○ Urine amount reduced
13 ○ ○ ○ Heart pounds after retiring
14 ○ ○ ○ "Nervous" stomach
15 ○ ○ ○ Appetite reduced
16 ○ ○ ○ Cold sweats often
17 ○ ○ ○ Body temperature rises easily
18 ○ ○ ○ Skin sensitive to touch
19 ○ ○ ○ Staring, blinks little
20 ○ ○ ○ Frequently has a sour stomach

----------- GROUP 2 ----------

21 ○ ○ ○ Joint stiffness after rising
22 ○ ○ ○ Muscle-leg-toe cramps at night
23 ○ ○ ○ "Butterfly" stomach, cramps
24 ○ ○ ○ Eyes or nose watery
25 ○ ○ ○ Eyes blink often
26 ○ ○ ○ Eyelids swollen or puffy
27 ○ ○ ○ Indigestion soon after meals
28 ○ ○ ○ Always seems hungry; "lightheaded" often
29 ○ ○ ○ Food digests rapidly
30 ○ ○ ○ Vomit frequently
31 ○ ○ ○ Frequently hoarse
32 ○ ○ ○ Irregular breathing
33 ○ ○ ○ Pulse slow or feels "irregular"
34 ○ ○ ○ Slow gag reflex
35 ○ ○ ○ Difficulty swallowing
36 ○ ○ ○ Alternating constipation and diarrhea
37 ○ ○ ○ "Slow starter"
38 ○ ○ ○ Not easily chilled
39 ○ ○ ○ Perspire easily
40 ○ ○ ○ Poor circulation or sensitive to cold
41 ○ ○ ○ Subject to colds, asthma, bronchitis

----------- GROUP 3 ----------

42 ○ ○ ○ Eat when nervous
43 ○ ○ ○ Excessive appetitie

1 2 3 ----------- GROUP 3 continued ----------

44 ○ ○ ○ Hungry between meals
45 ○ ○ ○ Irritable before meals
46 ○ ○ ○ Get "shaky" if hungry
47 ○ ○ ○ Feeling fatigued, eating relieves
48 ○ ○ ○ "Lightheaded" if meals delayed
49 ○ ○ ○ Heart palpitates if meals missed or delayed
50 ○ ○ ○ Afternoon headaches
51 ○ ○ ○ Upset feeling from excessive eating of sweets
52 ○ ○ ○ Awaken after few hours sleep hard to get back to sleep
53 ○ ○ ○ Crave candy or coffee in afternoons
54 ○ ○ ○ Moods of depression "blues" or melancholy
55 ○ ○ ○ Abnormal craving for sweets or snacks

----------- GROUP 4 ----------

56 ○ ○ ○ Hands and feet go to sleep easily, numbness
57 ○ ○ ○ Sigh frequently, "air hunger"
58 ○ ○ ○ Aware of "breathing heavily"
59 ○ ○ ○ Discomfort at high altitude
60 ○ ○ ○ Opens windows in closed room
61 ○ ○ ○ Susceptible to colds and fevers
62 ○ ○ ○ Afternoon yawner
63 ○ ○ ○ Get "drowsy" often
64 ○ ○ ○ Swollen ankles worse at night
65 ○ ○ ○ Muscle cramps, worse during exercise; "charley-horse"
66 ○ ○ ○ Shortness of breath on exertion
67 ○ ○ ○ Dull pain in chest or radiating into left arm, worse on exertion
68 ○ ○ ○ Bruise easily,"black/blue"spots on arms or legs
69 ○ ○ ○ Tendency to anemia
70 ○ ○ ○ Frequently have "nose bleeds"
71 ○ ○ ○ "Ringing in ears" or noises in head
72 ○ ○ ○ Tension under the breast-bone, or feeling of "tightness" in the chest, gets worse on exertion

----------- GROUP 5 ----------

73 ○ ○ ○ Dizziness
74 ○ ○ ○ Dry skin
75 ○ ○ ○ Burning feet
76 ○ ○ ○ Blurred vision
77 ○ ○ ○ Itching skin and feet
78 ○ ○ ○ Excessive falling hair
79 ○ ○ ○ Frequent skin rashes
80 ○ ○ ○ Bitter or metallic taste in mouth in the mornings
81 ○ ○ ○ Bowel movements painful or difficult
82 ○ ○ ○ Feelings of worry, dread, or insecurity
83 ○ ○ ○ Feeling queasy; headache over eyes
84 ○ ○ ○ Greasy foods upsets
85 ○ ○ ○ Stools light-colored
86 ○ ○ ○ Skin peels on foot soles
87 ○ ○ ○ Pain between shoulder blades
88 ○ ○ ○ Using laxatives
89 ○ ○ ○ Stools alternate from soft to watery
90 ○ ○ ○ History of gallbladder attacks or gallstones
91 ○ ○ ○ Sneezing attacks
92 ○ ○ ○ Dreaming, nightmares/bad dreams
93 ○ ○ ○ Bad breath (halitosis)
94 ○ ○ ○ Milk products cause distress
95 ○ ○ ○ Sensitive to hot weather
96 ○ ○ ○ Burning or itching anus
97 ○ ○ ○ Crave sweets

----------- GROUP 6 ----------

98 ○ ○ ○ Loss of taste for meat
99 ○ ○ ○ Lower bowel gas several hours after eating
100 ○ ○ ○ Burning stomach sensations, eating relieves
101 ○ ○ ○ Coated tongue
102 ○ ○ ○ Pass large amounts of foul smelling gas
103 ○ ○ ○ Indigestion 1/2-1 hour after eating; may be up to 3-4 hrs.
104 ○ ○ ○ Mucus colitis or "irritable bowel"
105 ○ ○ ○ Gas shortly after eating
106 ○ ○ ○ Stomach "bloating" after eating

	1	2	3	GROUP 7A
107	○	○	○	Insomnia
108	○	○	○	Nervousness
109	○	○	○	Can't gain weight
110	○	○	○	Intolerance to heat
111	○	○	○	Highly emotional
112	○	○	○	Flush easily
113	○	○	○	Night sweats
114	○	○	○	Skin is thin and moist
115	○	○	○	Inward trembling
116	○	○	○	Heart palpitates
117	○	○	○	Increased appetite without weight gain
118	○	○	○	Pulse races when resting
119	○	○	○	Eyelids and face twitch
120	○	○	○	Irritable and restless
121	○	○	○	Can't work under pressure
				GROUP 7B
122	○	○	○	Noticeable weight gain
123	○	○	○	Decrease in appetite
124	○	○	○	Easily fatigued
125	○	○	○	Ringing in ears
126	○	○	○	Sleepy during day
127	○	○	○	Sensitive to cold
128	○	○	○	Dry or scaly skin
129	○	○	○	Constipation
130	○	○	○	Mental sluggishness
131	○	○	○	Hair coarse, falls out
132	○	○	○	Headaches upon arising wear off during day
133	○	○	○	Pulse slow, below 65
134	○	○	○	Frequent urination
135	○	○	○	Impaired hearing
136	○	○	○	Reduced initiative
				GROUP 7C
137	○	○	○	Failing memory
138	○	○	○	Low blood pressure
139	○	○	○	Increased sex drive
140	○	○	○	Headaches, "splitting or rending" type
141	○	○	○	Decreased sugar tolerance
				GROUP 7D
142	○	○	○	Abnormal thirst
143	○	○	○	Bloating of the abdomen
144	○	○	○	Weight gain around hips or waist
145	○	○	○	Sex drive reduced or lacking
146	○	○	○	Tendency toward ulcers and/or colitis
147	○	○	○	Increased sugar tolerance
148	○	○	○	(FEMALE) Menstrual disorders
149	○	○	○	(YOUNG GIRLS) Lack of menstrual function
				GROUP 7E
150	○	○	○	Dizziness
151	○	○	○	Headaches
152	○	○	○	Hot flashes
153	○	○	○	Increased blood pressure
154	○	○	○	(FEMALE) Hair growth on face or body
155	○	○	○	Sugar in urine (not diabetes)
156	○	○	○	(FEMALE) Masculine tendencies
				GROUP 7F
157	○	○	○	Weakness and/or dizziness
158	○	○	○	Chronic fatigue
159	○	○	○	Low blood pressure
160	○	○	○	Nails weak and/or ridged
161	○	○	○	Tendency towards hives
162	○	○	○	Arthritic tendencies
163	○	○	○	Perspiration increase
164	○	○	○	Bowel disorders
165	○	○	○	Poor circulation
166	○	○	○	Swollen ankles
167	○	○	○	Crave salt
168	○	○	○	Brown spots or bronzing of skin
169	○	○	○	Allergies - tendency to asthma
170	○	○	○	Weakness after colds or influenza
171	○	○	○	Muscular and nervous exhaustion
172	○	○	○	Respiratory disorders

	1	2	3	GROUP 8
173	○	○	○	Apprehension
174	○	○	○	Irritability
175	○	○	○	Morbid fears
176	○	○	○	Never seems to get well
177	○	○	○	Forgetfulness
178	○	○	○	Indigestion
179	○	○	○	Poor appetite
180	○	○	○	Craving for sweets
181	○	○	○	Muscular soreness
182	○	○	○	Depression; feelings of dread
183	○	○	○	Noise sensitivity
184	○	○	○	Acoustic hallucinations
185	○	○	○	Tendency to cry without reason
186	○	○	○	Hair is coarse and/or thinning
187	○	○	○	Weakness
188	○	○	○	Fatigue
189	○	○	○	Skin sensitive to touch
190	○	○	○	Tendency towards hives
191	○	○	○	Nervousness
192	○	○	○	Headache
193	○	○	○	Insomnia
194	○	○	○	Anxiety
195	○	○	○	Anorexia
196	○	○	○	Inability to concentrate; confusion
197	○	○	○	Frequent stuffy nose; sinus infections
198	○	○	○	Allergy to some foods
199	○	○	○	Loose joints
				FEMALE ONLY
200	○	○	○	Very easily fatigued
201	○	○	○	Premenstrual tension
202	○	○	○	Painful menses
203	○	○	○	Depressed feelings before menstruation
204	○	○	○	Excessive and prolonged menstruation
205	○	○	○	Painful breasts
206	○	○	○	Menstruate too frequently
207	○	○	○	Vaginal discharge
208	○	○	○	Hysterectomy / ovaries removed
209	○	○	○	Menopausal hot flashes
210	○	○	○	Menses scanty or missed
211	○	○	○	Acne, worse at menses
212	○	○	○	Long standing depression
				MALE ONLY
213	○	○	○	Prostate trouble
214	○	○	○	Urination difficult or dribbling
215	○	○	○	Frequent night-time urination
216	○	○	○	Depression
217	○	○	○	Pain on inside of legs or heels
218	○	○	○	Feeling of incomplete bowel evacuation
219	○	○	○	Lack of energy
220	○	○	○	Migrating aches and pains
221	○	○	○	Too easily tired
222	○	○	○	Avoids activity
223	○	○	○	Leg nervousness at night
224	○	○	○	Diminished sex drive

List below your five main physical complaints in order of importance:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Notes:

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 the health practitioner and/or his/her 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)

CENTER FOR CHIROPRACTIC & WELLNESS OFFICE POLICIES

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

1. PAYMENT/COPAYMENT 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. Please call us if you need to cancel or reschedule an appointment. If a patient misses or cancels an appointment without 24 HOURS NOTICE, he/she will be responsible for a **CANCELLATION FEE OF $45**.
3. If the patient discontinues care for any reason, any balance is due and payable immediately, regardless of claims submitted. Any medical records including x-rays will not be released until the bill is paid in full.
4. 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.
5. Products purchased from this office are 100% REFUNDABLE within 7 days if the products are returned unopened.
6. There will be an additional $25 fee for returned or NSF checks.
7. Depending on the patient's insurance plan and coverage, this office will bill claims for him/her. This is a courtesy extended by this office and may be withdrawn at any time. The patient can opt to not bill his/her insurance in the state of North Carolina.
8. All insurance and contact information must be given to our office at the time of the patient's first visit. If any of this information changes, it is the patient's responsibility to notify the front desk immediately.
9. If the patient's insurance has a deductible, it will be assessed based on the charges incurred at this office.
10. This office does not guarantee any insurance company will or should make partial or full payment of fees charged. All claims are subject to review for coverage.
11. It is not this office's obligation to enter into a dispute with an insurance company concerning payment.
12. If 6 months or more lapse between a patient's chiropractic treatments, the next appointment scheduled will automatically be a chiropractic re-examination, which incurs an additional fee.
13. 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 payors.
14. Laboratory testing (varies by company) may or may not be covered by your insurance.
15. Medicare ***covers spinal adjustments only*** 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 doesn't cover Maintenance or Wellness care. If you choose these services, these are paid out of pocket at the Medicare rate.

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 of your scheduled appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because your treatment will help you recover.
3. If you are unable to make it due to an emergency, please call and let us know so that we can reschedule your appointment
4. With the exception of unexpected emergencies, please call and let us know at least 24 hours in advance to change the appointment.
5. All canceled or missed appointments must be rescheduled and made up within 1 week.
6. Service charges for missing an appointment are as follows:

15 min. Chiropractic/Nutrition Appointment $45
30 min. Chiropractic/Nutrition Appointment $60

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

Patient Signature ________________________________ Date________________

CENTER FOR CHIROPRACTIC & WELLNESS
231 N. Spring St., Suite A
Greensboro, NC 27401
336-285-7077

(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 Center for Chiropractic & Wellness 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 chiropractor 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.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date