

Welcome to Center for Chiropractic & Wellness! 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.GreensboroChiropractor.com](http://www.GreensboroChiropractor.com)

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CENTER FOR CHIROPRACTIC & WELLNESS

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION

Primary Insurance Co.

Subscriber’s Name

Relationship to Patient
Subscriber’s Birth Date
Subscriber’s SS#

Subscriber’s Employer

Is patient covered by additional insurance? Yes No

Secondary Insurance Co. Subscriber’s Name

Relationship to Patient
Subscriber’s Birth Date
Subscriber’s SS#

Subscriber’s Employer

ASSIGNMENT AND RELEASE

I understand and agree that health and accident insurance policies are an arrangement between me and
my insurance carrier. Furthermore, I understand that Center for Chiropractic & Wellness may prepare any necessary reports and forms to assist me in obtaining possible insurance reimbursement. However, I
clearly understand and agree that all services rendered to me are charged directly to me, and that I am
personally responsible for payment. I give Dr. Darcy Ward consent to examine and treat
myself or my minor child.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Parent or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Information taken by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTICE OF PRIVACY PRACTICES

I have received a copy of the HIPAA Privacy Regulations and understand that my private healthcare information is protected.

Signature of patient/parent Date

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List Chiropractors you have seen before:

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When Visited: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When Visited: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Medical Doctors consulted within the past year:

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all your reasons for visiting our office:
1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Reason for visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When \_\_\_\_\_\_\_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_
When \_\_\_\_\_\_\_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_
When \_\_\_\_\_\_\_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_
When \_\_\_\_\_\_\_\_\_\_\_ Hospitalized? Yes \_\_\_\_\_ No \_\_\_\_

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_ ADD/ ADHD \_\_\_ Depression

\_\_\_ Alcoholism \_\_\_ Diabetes

\_\_\_ Allergy \_\_\_ Diarrhea

\_\_\_ Alzheimer’s \_\_\_ Eczema

\_\_\_ Anemia \_\_\_ Emphysema

\_\_\_ Hepatitis

\_\_\_ High Blood Pressure \_\_\_ High Cholesterol

\_\_\_ High Blood Sugar \_\_\_ HIV/ AIDS

\_\_\_ Miscarriage

\_\_\_ Multiple Sclerosis \_\_\_ Neck Pain

\_\_\_ Parkinson’s Disease \_\_\_ Pneumonia

\_\_\_ Appendicitis \_\_\_ Epilepsy/seizures \_\_\_ Irregular Periods/Cramps \_\_\_Raynaud’s

\_\_\_ Asthma \_\_\_ Fibromyalgia

\_\_\_ Arthritis \_\_\_ Gall Bladder

\_\_\_ Back pain \_\_\_ Goiter

\_\_\_ Cancer \_\_\_ Gout
\_\_\_ Celiac/ Gluten Dis. \_\_\_ Headaches

\_\_\_ Chronic Fatigue \_\_\_ Heart Attack

\_\_\_ Constipation \_\_\_ Heart Disease

\_\_\_ Irritable Bowel

\_\_\_ Kidney infections/stones \_\_\_ Low Blood Pressure

\_\_\_ Low Blood Sugar \_\_\_ Lyme Disease

\_\_\_ Lupus

\_\_\_ Migraine

\_\_\_ Rheumatoid Arthritis \_\_\_ Ringing in Ears

\_\_\_ Sinus infections \_\_\_ Stroke

\_\_\_ Thyroid Problems \_\_\_ Ulcers

\_\_\_ Vertigo/dizziness

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

Mother: \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes

Father: \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes
GrandMother (M): \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes
GrandFather (M): \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes
GrandMother (P): \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes

GrandFather (P): \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes

Sisters: \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes

Brothers: \_\_Alzheimer’s \_\_Cancer \_\_ Diabetes

\_\_ Heart Disease \_\_Parkinson’s \_\_MS \_\_ Stroke
\_\_ Heart Disease \_\_Parkinson’s \_\_ MS \_\_ Stroke
\_\_Heart Disease \_\_Parkinson’s \_\_ MS \_\_ Stroke
\_\_ Heart Disease \_\_ Parkinson’s \_\_ MS \_\_ Stroke
\_\_ Heart Disease \_\_ Parkinson’s \_\_ MS \_\_ Stroke
\_\_ Heart Disease \_\_ Parkinson’s \_\_ MS \_\_Stroke

\_\_ Heart Disease \_\_ Parkinson’s \_\_ MS \_\_Stroke
\_\_ 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 unexplained or rapid 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:

P= pain, N= numbness, T= tingling, B= burning, C= cramping

CENTER FOR CHIROPRACTIC & WELLNESS

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? ß (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 ß (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? ß (CIRCLE) \_\_YES NO

Do you have tightness, or feelings of weakness in your hands or legs? ß (CIRCLE) \_\_\_\_YES NO

Do you ever have any numbness or tingling in your hands, legs, or face? ß (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? ß (CIRCLE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Do you ever experience increase tearing or salivation? ß (CIRCLE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Do you ever have slurred speech? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Noticed any drooping of your eyelids or facial muscles? ß (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? ß (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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

6

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 PRINTED NAME DATE

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT SIGNATURE

7

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8

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 abdominal pain relief by passing stool or gas Alternating constipation and diarrhea

Diarrhea

Constipation

Hard, dry, or small stool

Coated tongue of “fuzzy” debris on tongue Pass large amount of foul smelling gas

More than 3 bowel movements daily Use laxatives frequently

Category II

Excessive belching, burping, or bloating Gas immediately following a meal

Offensive breath

Difficult bowel movements

Sense of fullness during and after meals
Difficulty digesting fruits and vegetables;

undigested foods found in stools

Category III

Stomach pain, burning, or aching 1-4 hours after eating Use antacids

Feel hungry an hour or two after eating Heartburn when lying down or bending forward Temporary relief from antacids, food,

milk, carbonated beverages

Digestive problems subside with rest and relaxation Heartburn due to spicy foods, chocolate citrus,

peppers, alcohol, and caffeine

Category IV

Roughage and fiber cause constipation
Indigestion and fullness lasts 2-4 hours after eating Pain, tenderness, soreness on left side under rib cage Excessive passage of gas

Nausea and/or vomiting

Stool undigested, foul smelling, mucous-like,
 Greasy, or poorly formed

Frequent urination

Increased thirst and appetite Difficulty losing weight

Category V

0 1 2 3 Greasy or high-fat foods cause distress 0 1 2 3

0 1 2 3 Lower bowel gas and or bloating

0 1 2 3 several hours after eating 0 1 2 3

0 1 2 3 Bitter metallic taste in mouth,

0 1 2 3 especially in the morning 0 1 2 3

0 1 2 3 Unexplained itchy skin 0 1 2 3

0 1 2 3 Yellowish cast to eyes 0 1 2 3

0 1 2 3 Stool color alternates from clay colored

0 1 2 3 to normal brown 0 1 2 3

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

0 1 2 3 Have you had your gallbladder removed Yes No

0 1 2 3

0 1 2 3 Category VI

0 1 2 3 Crave sweets during the day 0 1 2 3

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

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

0 1 2 3 Agitated, easily upset, nervous 0 1 2 3

0 1 2 3 Poor memory/forgetful 0 1 2 3

0 1 2 3 Blurred vision 0 1 2 3

0 1 2 3

Category VII

0 1 2 3 Fatigue after meals 0 1 2 3

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

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

0 1 2 3 Difficulty losing weight 0 1 2 3

0 1 2 3

0 1 2 3 Category VIII

0 1 2 3 Cannot stay asleep 0 1 2 3

0 1 2 3 Crave salt 0 1 2 3

Slow starter in the morning 0 1 2 3

0 1 2 3 Afternoon fatigue 0 1 2 3

0 1 2 3 Dizziness when standing up quickly 0 1 2 3

0 1 2 3 Afternoon headaches 0 1 2 3

0 1 2 3 Headaches with exertion or stress 0 1 2 3

Weak nails 0 1 2 3

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Category IX Category XIV (Males only)

Cannot fall asleep 0 1 2 3 Urination difficulty or dribbling 0 1 2 3

Perspire easily 0 1 2 3 Frequent urination 0 1 2 3

Under high amounts of stress 0 1 2 3 Pain inside of legs or heels 0 1 2 3

Weight gain when under stress 0 1 2 3 Feeling of incomplete bowel evacuation 0 1 2 3

Wake up tired even after 6 or more hours of sleep 0 1 2 3 Leg nervousness at night 0 1 2 3

Excessive perspiration or perspiration with

little or no activity 0 1 2 3 Category XV (Males only)

Decrease in libido 0 1 2 3

Category X Decrease in spontaneous morning erections 0 1 2 3

Tired, sluggish 0 1 2 3 Decrease in fullness of erections 0 1 2 3

Feel cool- hands, feet, all over 0 1 2 3 Difficulty in maintaining morning erections 0 1 2 3

Require excessive amounts of sleep to Spells of mental fatigue 0 1 2 3

function properly 0 1 2 3 Inability to concentrate 0 1 2 3

Increase in weight gain even with low-calorie diet 0 1 2 3 Episodes of depression 0 1 2 3

Gain weight easily 0 1 2 3 Muscle soreness 0 1 2 3

Difficult, infrequent bowel movements 0 1 2 3 Decrease in physical stamina 0 1 2 3

Depression, lack of motivation 0 1 2 3 Unexplained weight gain 0 1 2 3

Morning headaches that wear off Increase in fat distribution around chest and hips 0 1 2 3

as the day progresses 0 1 2 3 Sweating attacks 0 1 2 3

Outer third of eyebrow thins 0 1 2 3 More emotional than in the past 0 1 2 3

Thinning of hair on scalp, face, or genitals or

Excessive falling hair 0 1 2 3 Category XVI (Menstruating Females Only)

Dryness of skin and/or scalp 0 1 2 3 Are you premenopausal Yes No

Mental sluggishness 0 1 2 3 Alternating menstrual cycle lengths Yes No

Extended menstrual cycle, greater than 24 days Yes No

Category XI Shortened menses, less than every 24 days Yes No

Heart palpitations 0 1 2 3 Pain and cramping during periods 0 1 2 3

Inward trembling 0 1 2 3 Scanty blood flow 0 1 2 3

Increased pulse even at rest 0 1 2 3 Heavy blood flow 0 1 2 3

Nervous and emotional 0 1 2 3 Breast pain and swelling during menses 0 1 2 3

Insomnia 0 1 2 3 Pelvic pain during menses 0 1 2 3

Night sweats 0 1 2 3 Irritable and depressed during menses 0 1 2 3

Difficulty gaining weight 0 1 2 3 Acne breakouts 0 1 2 3

Facial hair growth 0 1 2 3

Category XII Hair loss/ thinning 0 1 2 3

Diminished sex drive 0 1 2 3

Menstrual disorders or lack of menstruation 0 1 2 3 Category XVII (Menopausal Females Only)

Increased ability to eat sugars without symptoms 0 1 2 3 How many years have you been menopausal? \_\_\_\_\_\_\_\_\_\_\_\_

Since menopause, do you ever have uterine bleeding? Yes No

Category XIII Hot flashes 0 1 2 3

Increased sex drive 0 1 2 3 Mental fogginess 0 1 2 3

Tolerance to sugars reduced 0 1 2 3 Disinterest in sex 0 1 2 3

“Splitting” type headaches 0 1 2 3 Mood swings 0 1 2 3

Depression 0 1 2 3

PART III

How many alcoholic beverages do you consume per week? \_\_\_\_\_\_\_\_
How many caffeinated beverages do you consumer per day? \_\_\_\_\_\_\_

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

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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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CENTER FOR CHIROPRACTIC & WELLNESS

Darcy M. Ward, DC, BCIM

403 Parkway, Suite A

Greensboro, NC 27401

Phone (336) 285-7077 Fax (336) 285-7078

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

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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. Arthritis

f. Fibromyalgia

g. Depression

h. Chronic fatigue

i. Need surgery

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

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

What are you most concerned with regarding your problem?

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

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

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

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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