Dear Friend,

Welcome to Five Point Chiropractic & Whole Health! We are delighted that you have chosen us for your healthcare journey. We are dedicated to providing you with a holistic approach to your healthcare by taking actions and creating habits. Dr Guess recognizes that a person's physical health is intertwined with their mental, emotional, social and spiritual well-being. He emphasizes identifying and resolving the underlying causes of health issues, rather than just treating symptoms.

To ensure a smooth and productive first visit, please bring the following to your initial visit:

- Completed New Patient Intake Forms - These forms provide medical history and information about your current condition. You can find them on our website: fivepointchiro.com
- List of Medications and Supplements - Include all prescription medications, over-the -counter drugs, vitamins, herbs and any other supplements.
- Relevant Medical Records, Imaging Reports & Labs - If you have any recent X-rays, MRI reports, CAT scans, blood work or other relevant diagnostic studies.
- Food Diary – This is for Functional Medicine patients only, please keep a detailed food diary until the day of your visit.

What to Expect During Your First Visit:

The initial appointment, which typically lasts around an hour, will involve a comprehensive consultation and examination. The aim is to understand your unique needs and develop a personized treatment plan designed to help you achieve your health goals. The team looks forward to meeting you and helping you on your journey to better health and wellbeing! Our mission is to walk alongside you while inspiring you along the way…Changing lives one person at a time by taking actions and creating habits.

Warm Regards,

Dr. Chad Guess & Staff

Five Point Chiropractic

1101 Chestnut Street • Coshocton, Ohio 43812 • (740) 622-3553 (p) • (740) 622-5270 (f)

CONFIDENTIAL PATIENT INFORMATION

DATE _____

First Name _____ MI _____ Last Name _____

Address _____ Home Phone _____

City _____ State _____ ZIP _____ Cell Phone _____

SS# _____ Email _____

Date of Birth _____ Marital Status ☐M ☐S ☐W ☐D

Occupation _____ Employer _____

Chief Complaint _____

Are your present symptoms or condition related to or the result of an auto collision, work-related injury or other personal injury? ☐ Yes ☐ No If yes, explain _____

How did you hear about us?

- ☐ Our Website/the Internet
- ☐ Facebook/Social Media
- ☐ Friends/Family:
  - ➥ Who can we thank for your referral?: _____
- ☐ Other: _____

Preferred Method of Contact:

- ☐ Cell Phone (Call / Text)
- ☐ Home Phone (Call)

Have you been to a Chiropractor before? ☐ Yes ☐ No
If so, where?

Family Physician_____ May we send your health information to this provider? ☐ Yes ☐ No

Emergency Contact (name and phone)_____

Have you had any spinal X-rays / MRIs / CTs taken in the last year? ☐ Yes ☐ No If yes, where?_____

Do you have a pacemaker? ☐ Yes ☐ No Have you ever had hip or knee replacements? ☐ Yes ☐ No

Five Point
CHIROPRACTIC & WHOLE HEALTH

"Life isn't about finding yourself. Life is about creating yourself." - George Bernard Shaw

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Patient name _____ Date _____

TERMS OF ACCEPTANCE

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read the information below, and if you have any questions, feel free to ask one of our staff members.

INFORMED CONSENT

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non- duplicating health care service: Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Five Point Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

WOMEN ONLY:

To the best of my knowledge, ☐ I am / ☐ am NOT pregnant and ☐ give my permission / ☐ do NOT give my permission to X-ray me for diagnostic interpretation.

MISSED APPOINTMENTS

A fee may be charged for all missed appointments that are not canceled prior to the scheduled visit.

CONSENT TO EVALUATE AND TREAT A MINOR

I,_____ , being the parent or legal guardian of _____ , have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

COMMUNICATIONS

In the event that we would need to communicate your health information, to whom may we do so?

☐ Spouse_____

☐ Children_____

☐ Others_____

☐ No one

May we leave messages regarding your personal healthcare information on any answering device, i.e., home answering machines or voice mails? ☐ Yes ☐ No

ACKNOWLEDGMENT

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print name_____

Signature_____ Date_____

EHR CERTIFICATION INFORMATION

The U.S. government requires that we supply the following information about patients:

Name Date of Birth Chart #

PRESCRIBED MEDICATIONS AND VITAMINS

	medication	# of refills	quantity of pills	strength	dose form	M.D. instruction
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

☐ I am NOT taking any prescribed medication.

DRUG ALLERGIES

	medication (i.e., Penicillin)	symptom (i.e., headache)
1.		
2.		
3.		
4.		

☐ I do NOT have any medicinal allergies

SYSTEMS SURVEY FORM (restricted to professional use)

Patient Age Doctor Date

Circle the number that applies to you. If a symptom does not apply, leave it blank.
(**1**) for **MILD** symptoms (occurs rarely)
(**2**) for **MODERATE** symptoms (occurs several times a month)
(**3**) for **SEVERE** symptoms (occurs almost constantly)

GROUP ONE

1 • **1 2 3** Acid foods upset
2 • **1 2 3** Get chilled often
3 • **1 2 3** "Lump" in throat
4 • **1 2 3** Dry mouth/eyes/nose
5 • **1 2 3** Pulse speeds after meal
6 • **1 2 3** Keyed up, fail to calm
7 • **1 2 3** Cuts heal slowly
8 • **1 2 3** Gag easily
9 • **1 2 3** Unable to relax, startles easily
10 • **1 2 3** Extremities cold, clammy
11 • **1 2 3** Strong light irritates
12 • **1 2 3** Urine amount reduced
13 • **1 2 3** Heart pounds after retiring
14 • **1 2 3** "Nervous" stomach
15 • **1 2 3** Appetite reduced
16 • **1 2 3** Cold sweats often
17 • **1 2 3** Fever easily raised
18 • **1 2 3** Neuralgia-like pains
19 • **1 2 3** Staring, blinks little
20 • **1 2 3** Sour stomach frequent

GROUP TWO

21 • **1 2 3** Joint stiffness after arising
22 • **1 2 3** Muscle/leg/toe cramps at night
23 • **1 2 3** "Butterfly" stomach, cramps
24 • **1 2 3** Eyes or nose watery
25 • **1 2 3** Eyes blink often
26 • **1 2 3** Eyelids swollen, puffy
27 • **1 2 3** Indigestion soon after meals
28 • **1 2 3** Always seem hungry, feels "lightheaded" often
29 • **1 2 3** Digestion rapid
30 • **1 2 3** Vomiting frequent
31 • **1 2 3** Hoarseness frequent
32 • **1 2 3** Breathing irregular
33 • **1 2 3** Pulse slow, feels "irregular"
34 • **1 2 3** Gagging reflex slow
35 • **1 2 3** Difficulty swallowing
36 • **1 2 3** Constipation, diarrhea alternating
37 • **1 2 3** "Slow starter"
38 • **1 2 3** Get "chilled" infrequently
39 • **1 2 3** Perspire easily
40 • **1 2 3** Circulation poor, sensitive to cold
41 • **1 2 3** Subject to colds, asthma, bronchitis

GROUP THREE

42 • **1 2 3** Eat when nervous
43 • **1 2 3** Excessive appetite
44 • **1 2 3** Hungry between meals
45 • **1 2 3** Irritable before meals
46 • **1 2 3** Get "shaky" if hungry
47 • **1 2 3** Fatigue, eating relieves
48 • **1 2 3** "Lightheaded" if meals delayed
49 • **1 2 3** Heart palpitates if meals missed or delayed
50 • **1 2 3** Afternoon headaches
51 • **1 2 3** Overeating sweets upsets
52 • **1 2 3** Awaken after few hours' sleep, hard to get back to sleep
53 • **1 2 3** Crave candy or coffee in afternoons
54 • **1 2 3** Moods of depression, "blues" or melancholy
55 • **1 2 3** Abnormal craving for sweets or snacks

GROUP FOUR

56 • **1 2 3** Hands and feet go to sleep easily, numbness
57 • **1 2 3** Sigh frequently, "air hunger"
58 • **1 2 3** Aware of "breathing heavily"
59 • **1 2 3** High altitude discomfort
60 • **1 2 3** Opens windows in closed room
61 • **1 2 3** Susceptible to colds and fevers
62 • **1 2 3** Afternoon "yawner"
63 • **1 2 3** Get "drowsy" often
64 • **1 2 3** Swollen ankles worse at night
65 • **1 2 3** Muscle cramps, worse during exercise; get "charley horses"
66 • **1 2 3** Shortness of breath on exertion
67 • **1 2 3** Dull pain in chest or radiating into left arm, worse on exertion
68 • **1 2 3** Bruise easily, "black and blue" spots
69 • **1 2 3** Tendency to anemia
70 • **1 2 3** "Nose bleeds" frequent
71 • **1 2 3** Noises in head, or "ringing in ears"
72 • **1 2 3** Tension under the breastbone, or feeling of "tightness," worse on exertion

SYSTEMS SURVEY FORM (Page 2)

GROUP FIVE

73 • 1 2 3 Dizziness
74 • 1 2 3 Dry skin
75 • 1 2 3 Burning feet
76 • 1 2 3 Blurred vision
77 • 1 2 3 Itching skin and feet
78 • 1 2 3 Excessive falling hair
79 • 1 2 3 Frequent skin rashes
80 • 1 2 3 Bitter, metallic taste in mouth in mornings
81 • 1 2 3 Bowel movements painful or difficult
82 • 1 2 3 Worrier, feels insecure
83 • 1 2 3 Feeling queasy; headache over eyes
84 • 1 2 3 Greasy foods upset
85 • 1 2 3 Stools light-colored
86 • 1 2 3 Skin peels on foot soles
87 • 1 2 3 Pain between shoulder blades
88 • 1 2 3 Use laxatives
89 • 1 2 3 Stools alternate from soft to watery
90 • 1 2 3 History of gallbladder attacks or gallstones
91 • 1 2 3 Sneezing attacks
92 • 1 2 3 Dreaming, nightmare-type bad dreams
93 • 1 2 3 Bad breath (halitosis)
94 • 1 2 3 Milk products cause distress
95 • 1 2 3 Sensitive to hot weather
96 • 1 2 3 Burning or itching anus
97 • 1 2 3 Crave sweets

GROUP SIX

98 • 1 2 3 Loss of taste for meat
99 • 1 2 3 Lower bowel gas several hours after eating
100 • 1 2 3 Burning stomach sensations, eating relieves
101 • 1 2 3 Coated tongue
102 • 1 2 3 Pass large amounts of foul-smelling gas
103 • 1 2 3 Indigestion ½–1 hour after eating; may be up to 3–4 hours after
104 • 1 2 3 Mucous colitis or "irritable bowel"
105 • 1 2 3 Gas shortly after eating
106 • 1 2 3 Stomach "bloating"

GROUP SEVEN

(A)

107 • 1 2 3 Insomnia
108 • 1 2 3 Nervousness
109 • 1 2 3 Can't gain weight
110 • 1 2 3 Intolerance to heat
111 • 1 2 3 Highly emotional
112 • 1 2 3 Flush easily
113 • 1 2 3 Night sweats
114 • 1 2 3 Thin, moist skin
115 • 1 2 3 Inward trembling
116 • 1 2 3 Heart palpitates
117 • 1 2 3 Increased appetite without weight gain
118 • 1 2 3 Pulse fast at rest
119 • 1 2 3 Eyelids and face twitch
120 • 1 2 3 Irritable and restless
121 • 1 2 3 Can't work under pressure

(B)

122 • 1 2 3 Increase in weight
123 • 1 2 3 Decrease in appetite
124 • 1 2 3 Fatigue easily
125 • 1 2 3 Ringing in ears
126 • 1 2 3 Sleepy during day
127 • 1 2 3 Sensitive to cold
128 • 1 2 3 Dry or scaly skin
129 • 1 2 3 Constipation
130 • 1 2 3 Mental sluggishness
131 • 1 2 3 Hair coarse, falls out
132 • 1 2 3 Headaches upon arising wear off during day
133 • 1 2 3 Slow pulse, below 65

(B continued)

134 • 1 2 3 Frequency of urination
135 • 1 2 3 Impaired hearing
136 • 1 2 3 Reduced initiative

(C)

137 • 1 2 3 Failing memory
138 • 1 2 3 Low blood pressure
139 • 1 2 3 Increased sex drive
140 • 1 2 3 Headaches, "splitting or rendering" type
141 • 1 2 3 Decreased sugar tolerance

(D)

142 • 1 2 3 Abnormal thirst
143 • 1 2 3 Bloating of abdomen
144 • 1 2 3 Weight gain around hips or waist
145 • 1 2 3 Sex drive reduced or lacking
146 • 1 2 3 Tendency to ulcers, colitis
147 • 1 2 3 Increased sugar tolerance
148 • 1 2 3 Women: menstrual disorders
149 • 1 2 3 Young girls: lack of menstrual function

(E)

150 • 1 2 3 Dizziness
151 • 1 2 3 Headaches
152 • 1 2 3 Hot flashes
153 • 1 2 3 Increased blood pressure
154 • 1 2 3 Hair growth on face or body (female)
155 • 1 2 3 Sugar in urine (not diabetes)
156 • 1 2 3 Masculine tendencies (female)

(F)

157 • 1 2 3 Weakness, dizziness
158 • 1 2 3 Chronic fatigue
159 • 1 2 3 Low blood pressure
160 • 1 2 3 Nails weak, ridged
161 • 1 2 3 Tendency to hives
162 • 1 2 3 Arthritic tendencies
163 • 1 2 3 Perspiration increase
164 • 1 2 3 Bowel disorders
165 • 1 2 3 Poor circulation
166 • 1 2 3 Swollen ankles
167 • 1 2 3 Crave salt
168 • 1 2 3 Brown spots or bronzing of skin
169 • 1 2 3 Allergies - tendency to asthma
170 • 1 2 3 Weakness after colds, influenza
171 • 1 2 3 Exhaustion - muscular and nervous
172 • 1 2 3 Respiratory disorders

SYSTEMS SURVEY FORM (Page 3)

GROUP EIGHT

173 • 1 2 3 Muscle weakness
174 • 1 2 3 Lack of stamina
175 • 1 2 3 Drowsiness after eating
176 • 1 2 3 Muscular soreness
177 • 1 2 3 Rapid heartbeat
178 • 1 2 3 Hyper-irritable
179 • 1 2 3 Feeling of a band around head
180 • 1 2 3 Melancholia (feeling of sadness)
181 • 1 2 3 Swelling of ankles
182 • 1 2 3 Diminished urination
183 • 1 2 3 Tendency to consume sweets or carbohydrates
184 • 1 2 3 Muscle spasms
185 • 1 2 3 Blurred vision
186 • 1 2 3 Loss of muscular control
187 • 1 2 3 Numbness
188 • 1 2 3 Night sweats
189 • 1 2 3 Rapid digestion
190 • 1 2 3 Sensitivity to noise
191 • 1 2 3 Redness of palms of hands and bottom of feet
192 • 1 2 3 Visible veins on chest and abdomen
193 • 1 2 3 Hemorrhoids
194 • 1 2 3 Apprehension (feeling that something bad is going to happen)
195 • 1 2 3 Nervousness causing loss of appetite
196 • 1 2 3 Nervousness with indigestion
197 • 1 2 3 Gastritis
198 • 1 2 3 Forgetfulness
199 • 1 2 3 Thinning hair

FEMALE ONLY

200 • 1 2 3 Very easily fatigued
201 • 1 2 3 Premenstrual tension
202 • 1 2 3 Painful menses
203 • 1 2 3 Depressed feelings before menstruation
204 • 1 2 3 Menstruation excessive and prolonged
205 • 1 2 3 Painful breasts
206 • 1 2 3 Menstruate too frequently
207 • 1 2 3 Vaginal discharge
208 • 1 2 3 Hysterectomy/ovaries removed
209 • 1 2 3 Menopausal hot flashes
210 • 1 2 3 Menses scanty or missed
211 • 1 2 3 Acne, worse at menses
212 • 1 2 3 Depression of long standing

MALE ONLY

213 • 1 2 3 Prostate trouble
214 • 1 2 3 Urination difficult or dribbling
215 • 1 2 3 Night urination frequent
216 • 1 2 3 Depression
217 • 1 2 3 Pain on inside of legs or heels
218 • 1 2 3 Feeling of incomplete bowel evacuation
219 • 1 2 3 Lack of energy
220 • 1 2 3 Migrating aches and pains
221 • 1 2 3 Tire too easily
222 • 1 2 3 Avoids activity
223 • 1 2 3 Leg nervousness at night
224 • 1 2 3 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

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

TO BE COMPLETED BY DOCTOR

Postural Blood Pressure: Recumbent Standing Pulse

Hema-Combistix Urine readings: pH Albumin per cent Glucose per cent

Occult Blood pH Saliva pH Stool specimen Weight

Hemoglobin Blood Clotting Time

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D., and is a measurement of the underarm temperature to determine hypo- and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed, with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test (getting up for any reason, shaking down the thermometer, etc.). It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES	FEMALES HAVING MENSTRUAL CYCLES	MALES
Any two days during the month	The 2nd and 3rd day of flow OR any 5 days in a row	Any 2 days during the month

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. If you use a digital one, place the probe under your arm for 5 minutes, then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date:	Temperature:
Date:	Temperature:
Date:	Temperature:
Date:	Temperature:
Date:	Temperature:
Date:	Temperature:
Date:	Temperature: