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_____

PATIENT INTAKE FORM

Name _____ Date _____ Chart # _____

How often do you experience your symptoms? Select frequency for each area.

Neck	☐ Constant 75–100%	☐ Frequent 50–75%	☐ Occasional 25–50%	☐ Intermittent >25%
Mid-back	☐ Constant 75–100%	☐ Frequent 50–75%	☐ Occasional 25–50%	☐ Intermittent >25%
Low back	☐ Constant 75–100%	☐ Frequent 50–75%	☐ Occasional 25–50%	☐ Intermittent>25%
_____	☐ Constant 75–100%	☐ Frequent 50–75%	☐ Occasional 25–50%	☐ Intermittent>25%
_____	☐ Constant 75–100%	☐ Frequent 50–75%	☐ Occasional 25–50%	☐ Intermittent >25%

Using a scale from 1 to 10 (10 being the worst), rate your problem in each area. Then describe your pain for each area (sharp, dull, achy, burning, stiff, tingly, etc.).

Neck	1	2	3	4	5	6	7	8	9	10	_____
Mid-back	1	2	3	4	5	6	7	8	9	10	_____
Low back	1	2	3	4	5	6	7	8	9	10	_____
_____	1	2	3	4	5	6	7	8	9	10	_____
_____	1	2	3	4	5	6	7	8	9	10	_____

How are your symptoms changing with time? ☐ Getting worse ☐ Not changing ☐ Getting better

How much has the problem interfered with your work?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Substantially ☐ Extremely

How much has the problem interfered with your social activities?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Substantially ☐ Extremely

What other health care provider, treatments or results have you had for this problem?

_____

_____

How long have you had this problem? _____

How do you think your problem began? _____

Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem? _____

What makes the pain better? _____

How would you rate your overall health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None

Do you have difficulty falling asleep? ☐ Yes ☐ No Continuity disturbances? ☐ Yes ☐ No

Early awakenings? ☐ Yes ☐ No Daytime drowsiness? ☐ Yes ☐ No

PATIENT INTAKE FORM (Page 2)

Name _____ Date _____ Chart # _____

Please list IMMEDIATE family member(s) (mother, father, brother, sister, children) with any of the following:

Rheumatoid arthritis _____

Heart problems _____

Diabetes _____

Cancer _____

Gout _____

ALS _____

Place a check in the PAST column if you have had the condition in the past. If you presently have a condition, place a check in the PRESENT column.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	Headaches	☐	☐	High blood pressure	☐	☐	Diabetes
☐	☐	Neck pain	☐	☐	Heart attack	☐	☐	Excessive thirst
☐	☐	Upper back pain	☐	☐	Chest pains	☐	☐	Frequent urination
☐	☐	Mid-back pain	☐	☐	Stroke	☐	☐	HIV/AIDS
☐	☐	Low back pain	☐	☐	Angina	☐	☐	Drug/alcohol dependence
☐	☐	Shoulder pain	☐	☐	Kidney stones	☐	☐	Allergies
☐	☐	Elbow/upper arm pain	☐	☐	Kidney disorder	☐	☐	Depression
☐	☐	Wrist pain	☐	☐	Bladder infection	☐	☐	Systemic lupus
☐	☐	Hand pain	☐	☐	Painful urination	☐	☐	Epilepsy
☐	☐	Hip pain	☐	☐	Loss of bladder control	☐	☐	Dermatitis/eczema/rash
☐	☐	Upper leg pain	☐	☐	Prostate problems	☐	☐	Smoke/tobacco
☐	☐	Knee pain	☐	☐	Abnormal weight gain/loss			How many daily?_____
☐	☐	Ankle/foot pain	☐	☐	Loss of appetite			
☐	☐	Jaw pain	☐	☐	Abdominal pain			
☐	☐	Joint pain/stiffness	☐	☐	Ulcer			**WOMEN ONLY**
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Birth control pills
☐	☐	Rheumatoid arthritis	☐	☐	Liver /gall bladder disorder	☐	☐	Hormonal replacement
☐	☐	Cancer	☐	☐	General fatigue	☐	☐	Pregnancy #_____
☐	☐	Tumor	☐	☐	Muscular incoordination			
☐	☐	Asthma	☐	☐	Visual disturbances			1st day of last cycle_____
☐	☐	Chronic sinusitis	☐	☐	Dizziness			
								Length of cycle_____

List all surgeries and hospitalizations _____

_____

_____

What activities do you do at work?

Sit	☐ Most of the day	☐ Half the day	☐ A little of the day
Stand	☐ Most of the day	☐ Half the day	☐ A little of the day
Computer work	☐ Most of the day	☐ Half the day	☐ A little of the day
Drive	☐ Most of the day	☐ Half the day	☐ A little of the day

What activities do you do outside of work? _____

_____

Patient 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

NECK DISABILITY INDEX

Patient Name _____ Date _____

Score _____ % score _____

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please mark in each section the **ONE BOX** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **MOST CLOSELY** describes your present situation.

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

❍ 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 self-care.
❍ I do not get dressed. I wash with difficulty and stay in bed.

Section 3 • LIFTING

❍ I can lift heavy weights without causing extra pain.
❍ I can lift heavy weights, but it gives me extra pain.
❍ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, i.e., on a table.
❍ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
❍ I can lift only very light weights.
❍ I cannot lift or carry anything at all.

Section 4 • WORK

❍ I can do as much work as I want.
❍ I can only do my usual work, but no more.
❍ I can do most of my usual work, but no more.
❍ I can't do my usual work.
❍ I can hardly do any work at all.
❍ I can't do any work at all.

Section 5 • HEADACHES

❍ I have no headaches at all.
❍ I have slight headaches that come infrequently.
❍ 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.

Section 6 • CONCENTRATION

❍ I can concentrate fully without difficulty.
❍ I can concentrate fully with slight difficulty.
❍ I have a fair degree of difficulty concentrating.
❍ I have a lot of difficulty concentrating.
❍ I have a great deal of difficulty concentrating.
❍ I can't concentrate at all.

Section 7 • SLEEP

❍ I have no trouble sleeping.
❍ My sleep is slightly disturbed for less than 1 hour.
❍ My sleep is mildly disturbed for up to 1–2 hours.
❍ My sleep is moderately disturbed for up to 2–3 hours.
❍ My sleep is greatly disturbed for up to 3–5 hours.
❍ My sleep is completely disturbed for up to 5–7 hours.

Section 8 • DRIVING

❍ I can drive my car without neck pain.
❍ I can drive as long as I want with slight neck pain.
❍ I can drive as long as I want with moderate neck pain.
❍ I can't drive as long as I want because of moderate neck pain.
❍ I can hardly drive at all because of severe neck pain.
❍ I can't drive at all because of neck pain.

Section 9 • READING

❍ I can read as much as I want with no neck pain.
❍ I can read as much as I want with slight neck pain.
❍ I can read as much as I want with moderate neck pain.
❍ I can't read as much as I want because of moderate neck pain.
❍ I can't read as much as I want because of severe neck pain.
❍ I can't read at all.

Section 10 • RECREATION

❍ I have no neck pain during all recreational activities.
❍ I have some neck pain with a few recreational activities.
❍ I have some neck pain with all recreational activities.
❍ I have neck pain with most recreational activities.
❍ I can hardly do recreational activities due to neck pain.
❍ I can't do any recreational activities due to neck pain.

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REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

Patient Name _____ Date _____

Score _____ % score _____ % disability _____

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by marking the **ONE CHOICE THAT MOST APPLIES TO YOU TODAY.**

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 severe.
❍ The pain is severe and does not vary much.

Section 2 • PERSONAL CARE (washing, dressing, etc.)

❍ I do 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.
❍ Washing and dressing increases the pain and I find it necessary 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.
❍ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
❍ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
❍ I can lift only 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 1 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 sit in my favorite chair as long as I like.
❍ Pain prevents me from sitting for more than 1 hour.
❍ Pain prevents me from sitting for more than ½ hour.
❍ Pain prevents me from sitting for more than 10 minutes.
❍ I avoid sitting because it increases pain immediately.

Section 6 • STANDING

❍ I can stand as long as I want without pain.
❍ I have some pain on standing but it doesn't 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 without increasing pain.
❍ I avoid standing because it increases the pain immediately.

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 night's sleep is reduced by less than ½.
❍ Because of 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 me no pain.
❍ My social life is normal but increases the degree of my 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 • TRAVEL

❍ I get no pain while traveling.
❍ I get some pain while traveling, but none of my usual forms of travel make 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.

Section 10 • CHANGING DEGREE OF PAIN

❍ My pain is rapidly getting better.
❍ My pain fluctuates, but overall is definitely getting better.
❍ My pain seems to be getting better, but improvement is slow at present.
❍ My pain is neither getting better nor worse.
❍ My pain is gradually worsening.
❍ My pain is rapidly worsening.