Five Points Chiropractic ~ 920 S. Milledge Ave ~ Athens, GA 30605 ~ 706-546-7700 ~ www.FivePointsChiropractic.com

# Patient Entrance History

## 1. PATIENT INFORMATION

Date_____
First Name: _____ Middle _____
Last Name:_____
Address:_____
City: _____State:_____ Zip: _____

Sex: M F Age:_____ Birthdate: _____
Single Married Divorced Widowed Separated

Occupation:_____
Employer:_____
Employer address _____
Spouse's Name: _____
Occupation:_____
Employer:_____
Names and ages of children:

_____
_____

Who referred you to our office?
_____

## 2. INSURANCE

Who is responsible for account? _____
Relationship to Patient _____
Insurance Co. _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birthdate _____ SS#_____
Relationship to patient _____

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with above named insurance company and assign directly to Dr. Huppert all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am financially responsible for all charges if I do not have insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

## 3. PHONE NUMBERS

Home _____ Cell _____
Work _____ Ext. _____
May we contact you at work? Y / N
Would you like text appointment reminders? Y / N
Cell Phone Provider _____
E-mail Address _____

### IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship_____
Home Phone _____ Work Phone _____

## 4. ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date: _____

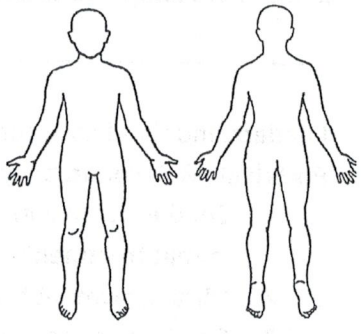
Type of accident: ☐ Auto ☐ Work ☐ Home ☐ _____

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ _____

Attorney Name (if applicable) _____

## 5. PATIENT CONDITION

Primary Concern _____
When did your symptoms appear? _____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of your pain on a scale of 1 (least pain) or 10 (severe pain) _____
Type of pain (circle all that apply) Sore Dull Aching Sharp Stabbing Burning
Tingling Numbness Other _____
How often do you have this pain? _____



Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform: ☐ Bending ☐ Laying Down ☐ Sitting ☐ Standing
Activities or movements that make it feel better: ☐ Lying Down ☐ Sitting ☐ Standing ☐ Rest ☐ Movement
What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic ☐ None ☐ Other_____

Last Name: _____ First Name _____ Date _____

# 6. HEALTH HISTORY

**Please check any of the following symptoms you have experienced in the past 6 months.**

__ Carpal Tunnel Syndrome
__ Cold/Flu
__ Difficulty Breathing
__ Digestive Problems
__ Dizziness
__ Fibromyalgia
__ Headaches
__ Joint Problems
__ Leg and Hip Problems
__ Loss of Energy/Fatigue
__ Low Back Pain
__ Mid Back Pain
__ Neck Pain
__ Sciatica
__ Stiffness
__ Stressed Shoulders
__ Tingling or Numbness
__ TMJ Problems
__ Upper Back Pain
__ Other _____

**Have you ever been diagnosed or told you have one of the following diseased, disorders, or medical conditions?**

__ AIDS/HIV
__ Allergies
__ Arthritis
__ Artificial Bones/Joint
__ Asthma
__ Cancer _____
__ Chemical Dependency
Congenital Heart Defect
__ Diabetes
__ Ear Infections
__ Fainting/Seizures
__ Gout
__ Hearing Problems
__ Heart Attack
__ Hepatitis
Herniated Disk
__ High/Low Blood Pressure
__ High Cholesterol
__ Kidney Problems
__ Liver Disease
__ Loss of Bowel/Bladder Control
__ Pacemaker
__ Scoliosis
Sinus Problems
__ Stroke
__ Thyroid Problems
__ Tuberculosis
__ Ulcers/Colitis
__ Whiplash
__ Other _____

## HABITS

__ Smoking Packs/Day_____
__ Coffee/Caffeine Cups/Day _____
__ Alcohol Drinks/Week _____
__ High Stress Level Reason _____

## MEDICAL HISTORY

Date of last MRI, CT-Scan, Bone Scan or other _____
Name of Doctors who have treated you for your condition
_____
Name of your Primary Physician _____

**Injuries and Surgeries you have had**

**Description and Date**

Falls/Accidents_____
Head Injuries _____
Broken Bones _____
Surgeries _____

## EXERCISE

__ None __ Moderate __ Daily __ Heavy

## WORK ACTIVITY

__ Sitting __ Standing __Light Labor
__ Heavy Labor __Computer __ Driving

## 7. MEDICATIONS, VITAMINS, and SUPPLEMENTS (name and purpose)

_____

_____

***Is there anything else which may help us to better understand your history which has not been discussed on this survey?***

_____

***Notice of Privacy Practices Acknowledgement***

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

**Signature:** _____ **Date:** _____

Five Points Chiropractic

Patient's Name: _____ HR#: _____

# ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| ACTIVITIES: | EFFECT: | | | |
|---|---|---|---|---|
| Carrying Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sit to Stand | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Climbing Stairs | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Pet Care | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Extended Computer Use | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Lifting Children | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Reading/Concentration | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Bathing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Dressing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Shaving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sexual Activities | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sleeping | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Static Sitting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Static Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Doing Yard work | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Washing/Bathing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sweeping/Vacuuming | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Doing Dishes | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Doing Laundry | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Taking out Garbage | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Other: _____ | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |

Patient signature: _____ Today's Date: ___/___/___

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

**Please read carefully:**

**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

**Example:**

| | Headache | | | | Neck | | | | Low Back | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | 0 | 1 | (2) | 3 | 4 | (5) | 6 | 7 | (8) | 9 | 10 | **worst possible pain** |

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**1 – What is your pain RIGHT NOW?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **worst possible pain** |

**2 – What is your TYPICAL or AVERAGE pain?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **worst possible pain** |

**3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **worst possible pain** |

**4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **worst possible pain** |

**OTHER COMMENTS:**

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

# Five Points Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

**PERMITTED DISCLOSURES:**

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or up-coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

**COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call the office manager at (706) 546-7700. If she/he is unavailable, you may make an appointment with our receptionist to see her/him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

*Patient initials: _____-**retaining page 1 of 2***

***Five Points Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....***

I have received a copy of Five Points Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

| _____ | _____ | _____ |
|---|---|---|
| Patient's Name | DOB | HR# |
| _____ | _____ | |
| Patient signature | Date | |
| _____ | _____ | |
| Witness | Date | |



**FPC 1/2017**