Name ____ Date ____________

Address ____

City ______________________ State ________________ Zip Code________________

Cell Phone ____

Age __________ Birth Date______/_______/_______ Sex: ☐ MALE ☐ FEMALE

Your Occupation ____

Email ____ Marital Status: ☐S ☐M ☐D ☐W

Spouse's Name ________________ Occupation ____________________________

INDICATE BELOW WHERE YOU HAVE PAIN/SYMPTOMS:

- ☐ HEADACHE
- ☐ NECK PAIN
- ☐ SHOULDER PAIN
- ☐ PAIN BETWEEN SHOULDERS
- ☐ ELBOW PAIN
- ☐ SPRAIN / STRAIN
- ☐ NUMBNESS OR TINGLING IN ARM OR LEG
- ☐ **NO PAIN/DISCOMFORT**
- ☐ HIP PAIN
- ☐ KNEE PAIN
- ☐ ANKLE / FOOT PAIN
- ☐ LOW BACK PAIN
- ☐ BROKEN BONES
- ☐ UPPER BACK PAIN
- ☐ WRIST HAND PAIN
- ☐ STIFFNESS/TIGHTNESS
- ☐ OTHER: ________________________

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain?

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other:____________

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

(CIRCLE A NUMBER) 0 1 2 3 4 5 6 7 8 9 10

How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately Quite a bit ☐ Extremely

Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER physician ☐ Orthopedist ☐ Other:________
☐ Massage Therapist ☐ Physical Therapist ☐ No one

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 concerns you the most about your problem; what does it prevent you from doing?

____

What is your: Height______________ **Weight** ____________

How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

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

Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	**Jaw Pain**	□	□	**High Blood Pressure**	□	□	**Diabetes**
□	□	**Joint Pain/Stiffness**	□	□	**Heart Attack**	□	□	**Excessive Thirst**
□	□	**Arthritis**	□	□	**Chest Pains**	□	□	**Frequent Urination**
□	□	**Cancer**	□	□	**Stroke**	□	□	**Smoking/Tobacco Use**
□	□	**Tumor**	□	□	**Angina**	□	□	**Drug/Alcohol Dependance**
□	□	**Asthma**	□	□	**Kidney Stones**	□	□	**Allergies**
□	□	**Chronic Sinusitis**	□	□	**Kidney Disorders**	□	□	**Depression**
□	□	**Dizziness**	□	□	**Bladder Infection**	□	□	**Systemic Lupus**
□	□	**Loss of Appetite**	□	□	**Painful Urination**	□	□	**Epilepsy**
□	□	**Abdominal Pain**	□	□	**Loss of Bladder Control**	□	□	**Dermatitis/Eczema/Rash**
□	□	**Ulcer**	□	□	**Prostate Problems**	□	□	**HIV/AIDS**
□	□	**Hepatitis**	□	□	**General Fatigue**			**FOR FEMALES ONLY**
□	□	**Visual Disturbances**	□	□	**Abnormal Weight Gain/Loss**	□	□	**Birth Control Pills**
			□	□	**Muscular Incoordination**	□	□	**Hormone Replacement**
						□	□	**Pregnancy**
□	□	**Other**_______________						

Prescription Medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?
____

List all of the over-the-counter medications you are currently taking:
____

List all surgical procedures you have had:
____

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
□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

What activities do you do outside of work?
____

Have you ever been hospitalized? □ No □ Yes
if yes, why ____

Have you had significant past trauma? □ YES □ NO
Were You Ever in An Auto Accident? □ YES □ NO DATE OF INCIDENT ____________________

Anything else pertinent to your visit today?____

PLEASE CHECK THE *ONE* BOX THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH.

❑ I AM ONLY CONCERNED ABOUT THE RELIEF OF A PARTICULAR SYMPTOM.

❑ I AM ONLY CONCERNED ABOUT THE RELIEF OF A PARTICULAR SYMPTOM, AND PREVENTING ITS RETURN.

❑ I WANT OPTIMUM HEALTH AND WELL-BEING ON EVERY LEVEL AVAILABLE TO ME.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY AND SIGN. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Testimonials: I give Beyond Wellness Chiropractic permission to, use my testimonial with or without my name, photograph, and/or video testimonial: in ads, brochures, on the Web site, and in other promotions used to market their services, in the interest of telling others about the benefits of chiropractic.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open setting with other patients where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used if we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency. In addition, we may occasionally video tape our front desk or open adjustment area for training purposes. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You nay revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object
We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Dennis Hupka, Chiropractor (843) 800-0373
589 Belle Station Blvd, Mount Pleasant SC 29464

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Dennis J. Hupka, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. **"You May Refuse To Sign This."**
I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON November 1, 2020.

Printed Patient Name ____ **Date** __________________________________

Signature ____

Printed Name of Parent/Guardian ____

Signature of Parent/Guardian ____

THIS AGREEMENT is made and entered into by and between the named patient and provider. Whereas, patient desires to receive services from this health care provider and therefore desires to assign certain rights and benefits to provider it is hereby agreed:

A. When we accept you as a patient it's important that you understand the objectives of our care. Chiropractors provide a unique service that no other healthcare providers offer. Chiropractors specialize in the location and correction of vertebral subluxations for the purpose of improving the health and function of your spine and nervous system. **The purpose of chiropractic care, in this office, is not to treat disease, suppress symptoms, perform surgery or prescribe medications but rather to improve the health and function of your spine and nerve system.** Our primary objective is to improve and maintain the health and normal function of your spine and nerve system to the maximum degree possible, using specialized techniques called "chiropractic or spinal adjustments" over a period of time. It is not our objective to prescribe medication, medically diagnose or treat disease. If you desire diagnosis or treatment for a disease or condition or advice on taking or stopping medications, we recommend you consult a healthcare provider who specializes in that area.

B. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or his/her preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

C. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fracture, disc injury, apoplexy, dislocation and sprain. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

If we discover unusual findings during the course of our chiropractic examination(s) we will discuss them with you. You may then decide whether you wish to investigate further and discuss your healthcare options with other health professionals. We are happy to communicate our concerns with any other health professional.

D. Client recognizes that this agreement is not a guarantee of clinical results. There is no guarantee that any illness, injury, or disease can be prevented or cured by participation in this program. Any balance due for services are due regardless of results. This agreement is non-transferable and constitutes the complete agreement between patient and provider. No other chiropractic facilities are covered by this agreement. This agreement does not constitute insurance and as such provider makes no promises to treat new conditions under this agreement.

E. Patient hereby authorizes this provider to release and permit the examination and/or copying of any of patient's medical records, x-rays, laboratory reports and the results of all tests of any time or character to such persons as provider deems appropriate.

F. The assignments and agreements contained in this document may not be revoked by patient without the express consent of the provider. We reserve the right to cancel agreement at any time for any reason. This agreement is non-transferable and non-refundable.

I understand the purpose of chiropractic care as explained above I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic care in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent. I consent to the chiropractic care offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

____

Signature Date Spouse/parent Signature Date

____

Staff Signature Date