# GUEST CHIROPRACTIC CENTER

Dr. Wesley G Hays
9438 Asheville Hwy
Inman, SC 29349
P: 864-578-3001
F: 864-578-7001
hayschiro@bellsouth.net

**Confidential Patient Health Record**

Date: _____

## Personal History

_____ _____

Last Name First Name MI Address

_____

City State Zip Code

Birth Date: _____ Sex: Famale E-Mail address: _____

Cell Phone: _____ Home/Work Phone: _____

Circle One: Married⊙Single○Widowed○Divorced○Separated○Driver's License #: _____

Employer: _____ Type of Work: _____

Spouse's Name: _____ Spouse's Employer: _____

Referred to this office by _____

Name & Number of Emergency Contact: _____ Relationship _____

Who is responsible for your bill, you and?(Circle One) Self Worker's Comp. Auto Insurance Medicare Health Insurance

Insured Person's Name: _____ Date of Birth: _____

## Current Health Condition

Condition bringing you to us? _____

Other doctors seen for this condition? No Who? _____

When did this condition begin? _____ Has this condition occurred before? No

How did symptoms begin? Gradual ○ Sudden ○ Progressive over time ○

What makes symptoms worse? _____ Better? _____

Type of Pain: Sharp○Dull○Ache○Burn○Throb○ Does Pain radiate? No Location: Arm ○ Leg ○

Do you experience numbness or tingling? No

How often do you experience these symptoms? 10%○ 25%○50%○75%○100%○

Pain Intensity: Please circle the number on the scale which best describes the intensity of your pain.

No Pain 0 Worse Pain

Is this condition: Job related○Auto Accident○Home Injury○Fall○Other _____

Date of Accident: _____ Have you reported accident to appropriate people? No

Prescriptions You Take: _____

Do you suffer from any condition other than that which you are now consulting us? _____

## Past Health History

Please circle all major surgeries that apply: Appendectomy☐Tonsillectomy☐Gall Bladder☐Hernia☐Back Surgery☐

Prostate Rotator Cuff Hysterectomy Broken Bones Other: _____

Major Accidents or Illnesses: _____

Hospitalization (other than above) _____

Previous Chiropractic Care: No Doctor's Name: _____ Last Visit: _____

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## New Patient Questionnaire

Below is a list of diseases which may seem unrelated to the purpose of your visit. However, these questions need be answered accurately, as these problems can affect how we care for you. Please be upfront so we can give you the best treatment possible. Your honesty only benefits you and adds to your overall wellness. Details of these ailments can be discussed with the doctor.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE OR HAVE HAD:**

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes: _____
- ☐ Cancer: _____
- ☐ Heart Disease
- ☐ Thyroid Problems
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

**INTAKE:**

- ☐ Caffeine (coffee/tea)
- ☐ White Sugar
- ☐ Alcohol
- ☐ Tobacco
- ☐ Vapes/E-Cigarettes
- ☐ Illegal Drugs
- ☐ Rx Medications

*Have you been tested HIV Positive?* No

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 6 MONTHS:**

**MUSCULO-SKELETAL**

- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking jaw
- ☐ General Stiffness

**NERVOUS SYSTEM**

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Unwarranted Anxiety/Stress

**GENERAL**

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

**GASTRO-INTESTINAL**

- ☐ Poor/Excessive Appetite
- ☐ Excessive thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Issues
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating after meals
- ☐ Heartburn
- ☐ Black/Bloody stool
- ☐ Colitis

**GENITO-URINARY**

- ☐ Bladder Troubles
- ☐ Painful/Excessive urination
- ☐ Discolored Urine

**C-V-R**

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problems
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Lung problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle swelling
- ☐ Stroke

**EENT**

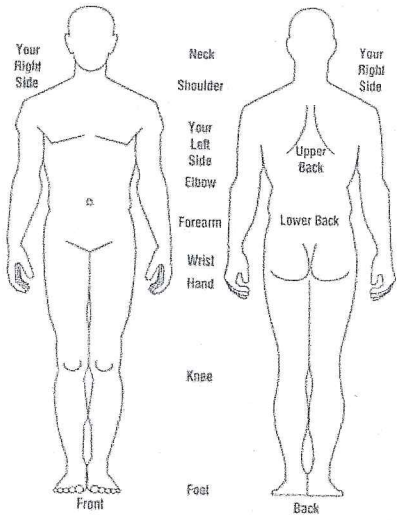
- ☐ Vision problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear aches
- ☐ Hearing issues
- ☐ Stuffed nose

**FEMALES:**

- ☐ Menstrual irregularity
- ☐ Menstrual cramps
- ☐ Vaginal pain/infection
- ☐ Breast pain/lumps
- ☐ Last period: _____
- ☐ Are you pregnant? Unsure
- ☐ Other Issues _____

**MALES:**

- ☐ Prostate/Sexual Dysfunction
- ☐ Other Issues _____




***Please use the diagram above to best indicate your areas of discomfort***

**FAMILY HISTORY**

The following relatives have the same/similar issues as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

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## AUTHORIZATION FOR EXAM, X-RAYS, TREATMENTAND RELEASE OF INFORMATION

I, the undersigned, a patient in this office, hereby authorize *Dr. W. G. Hays* (and whomever he may designate as his assistants) to examine me. Examination may include X-rays, if indicated by the exam. X-rays have been proven harmful to the body, and for this reason if you are pregnant, you must tell us.

**Are You Pregnant? YES ◯ NO ◯**

Furthermore, I authorize *Dr. W. G. Hays* (and whomever he may designate as his assistants) to administer such treatment as is necessary, which may include Chiropractic Adjustments, and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I hereby certify that I have read and fully understand the above Authorization for Examination, X-ray and Chiropractic Treatments, the reasons why the above treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by *Dr. W. G. Hays* or the examining doctor. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

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## ASSIGNMENT AND AUTHORIZATION

TO: Guest Chiropractic Center
9438 Asheville Hwy
Inman SC 29349

In consideration of your agreeing to treat me; I agree to the following:

1. I hereby attest to the accuracy of my medical and/or accident history and further certify that I present myself to *Guest Chiropractic Center* for evaluation and/or treatment of a health related condition and for no other purpose. I clearly understand that I am totally responsible for payment should the insurance company deny payment or makes payment to me.
2. I hereby irrevocably assign to you any right, title, interest, claim and/or assignment I may have against any insurance company obligated to make any type of payment for your charges, whether based on first party coverage or third party coverage. **I authorize and direct payment to Guest Chiropractic Center** of any sum which may become due under any contract of insurance covering your services.
3. Should any such insurance company fail to make payment, full payment, or prompt payment, of any claim, I hereby assign and transfer to you any cause of action that might exist in my favor against such insurance company, and you shall be substitute in full place instead of me as a Plaintiff in any litigation arising out of such cause of action. Any and all charges, fees and/or expenses incurred from any payment/collection will be charged to the insurance company.
4. I understand that you will make all reasonable efforts to collect any insurance benefits under any such policies before you proceed with any attempts to collect sums not paid by the insurance company from me.
5. **You are authorized to release and/or request any information you deem appropriate concerning my physical condition, treatment to or from and/or historical information that may be pertinent to the my health condition from any insurance company, attorney, adjuster or doctor. This may be done in order to process any claim for reimbursement for any charges incurred by me or any services rendered.**
6. All documentation no matter how requested or received will be conveyed with all possible security and confidentiality. The patient's information shall remain secure and confidential until statutory limitations of South Carolina are met, and then properly disposed by destruction or incineration.
7. A photo-static copy of this authorization shall be considered as effective and valid as the original.

**Signature:** _____ **Print Name:** _____

**Witnessed by:** _____ **Date:** _____

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# PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act pf 1996* (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of this disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Dr. Wesley G. Hays's *Notice of Privacy Practices for Protected Health Information.*

_____ _____

*Patient Name Printed* *Date*

_____ _____

*Patient Signature* *Guardian Signature*