

Patient Health Record

Welcome to our Acupuncture Office.

Please fill out our confidential Patient Health Record completely and accurately. If you have any questions, please don't hesitate to ask.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being via specific acupuncture care.

Pathways Chiropractic & Wellness

2600 Gateway Ave. Suite 2

Bismarck, ND 58503

ABOUT THE PATIENT

Name _____

Address _____

City _____ State _____ Zip _____

Age _____ Birthdate _____

Gender – M or F Number of Children _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____

Marital Status – Married Single

Widowed Divorced

Social Security # _____

E-Mail Address _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment related to:

Job Sports Auto Fall

Chronic Discomfort Injury

Please Explain _____

When did this condition begin? _____

Has this condition: gotten worse

stayed constant comes and goes

Does this condition interfere with:

work sleep daily routine

Has this condition occurred before? Yes No

If yes, explain. _____

Have you seen other doctors for this condition?

Yes No

Dr.'s Name(s) _____

Types of Treatment _____

Results _____

ABOUT THE SPOUSE OR PARENT

Name _____

Date of Birth _____

Employer _____

Work Phone _____

EXPERIENCE WITH ACUPUNCTURE

Who referred you to this office? _____

Have you been treated with acupuncture before? Yes No

Reasons for those visits? _____

Approximate Date of Last Visit _____

MEDICATIONS I NOW TAKE

Nerve Pills	Stimulants
Pain Killers	Blood thinners
Muscle Relaxers	Aspirin
Blood Pressure Medicine	Tylenol
Insulin	Cholesterol Medicine
Other _____	Other _____

HEALTH HABITS

Do you smoke?	No	Yes	_____	packs/day
Do you drink alcohol?	No	Yes	_____	drinks/week
Do you drink coffee?	No	Yes	_____	cups/day
Do you exercise regularly?	No	Moderate	Daily	

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- Severe or Frequent Headaches
- Sinus problems
- Dizziness
- Loss of Sleep
- Pain between the Shoulders
- Frequent Neck Pain
- Numbness or Pain in Arms/Legs/Hands
- Lower Back Problems
- Digestive Problems
- Ulcers/Colitis
- Heart Attack/Stoke
- Depressed
- Irritable
- Hemorrhoids
- Bedwetting
- Learning disabilities

- Congenital Heart Defect
- Heart Surgery/Pacemaker
- Heart Murmur
- High/Low Blood Pressure
- Difficulty Breathing
- Asthma
- Arthritis
- Alcohol/Drug Abuse
- Diabetes
- Kidney Problems
- Hepatitis
- Cancer
- Anemia
- Thyroid Problems
- Trouble Sleeping
- Prostate problems
- Ear infections

For Women:

Are you pregnant?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control?	Yes	No
Do you experience painful periods?	Yes	No
Do you have irregular cycles?	Yes	No

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of acupuncture to my body, as he or she deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. If the Doctor does accept my case, it does not guarantee nor does it imply a guarantee of being able to cure or prevent any condition illness or injury.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

Patient's signature	Date	Guardian or Spouse's Signature Authorizing Care	Date
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IN AN EMERGENCY, CONTACT:

Name _____
Relationship _____
Work Phone _____
Home Phone _____

Patient Acknowledgement For Receipt Of HIPAA Compliance Information

Please complete the information below. Whether you are a new patient and recently provided us with this information or if there have been no changes since you started care we are required to have this acknowledgment on file in your hand.

Thank You!

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Patient Signature: _____ **Date:** _____

Pathways Chiropractic & Wellness

Dr. Bethany Holwegner-Dr. Ryan Koch
2600 Gateway Ave., Suite 2
Bismarck, ND 58503

Informed Consent for Acupuncture Care

When a patient seeks acupuncture health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo acupuncture care after being advised of the known benefits, risks and alternatives.

Acupuncture is a science and art which concerns itself with the relationship between the body's Qi and function as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Practitioners of acupuncture and Chinese medicine have used this noninvasive medical system to diagnose and help millions of people get well and stay healthy.

An acupuncturist will place fine, sterile needles at specific acupoints on the body. This activates the body's Qi and promotes natural healing by enhancing recuperative power, immunity and physical and emotional health. It can improve overall function and well-being. It is a safe, painless and effective way to treat a wide variety of medical problems.

If during the course of care we encounter non-acupuncture or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of acupuncture care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept acupuncture care on this basis.

Print Name

Signature

Date

Consent to evaluate and treat a minor child:

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

