

Patient Health Record

Welcome to our Chiropractic 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 chiropractic 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 CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a chiropractor 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

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

- | | | |
|--|-----|----|
| • ...Doctors of Chiropractic work with the nervous system? | Yes | No |
| • ...the Nervous System controls all bodily functions and systems? | Yes | No |
| • ...Chiropractic is the largest natural healing profession in the world? | Yes | No |
| • ...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? | Yes | No |

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, 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 have been advised that this office offers all patients and 3rd party payers a discount for services when the services are paid in full at the time of service or pre-paid in advance of services. 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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Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

IN AN EMERGENCY, CONTACT:

Name _____

Relationship _____

Work Phone _____

Home Phone _____

INSURANCE INFORMATION

At PCW we accept most insurance plans. We will happily check your benefits for you and directly bill the insurance company for services covered *per your policy* with the following understanding:

Health and accident insurance policies are an arrangement between the insurance carrier and the insured. Benefits quoted by an insurance company over the phone are not a guarantee of payment. The insured is responsible for all deductibles, co-payments and unpaid services rendered.

Insurance Company Name: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Patient Signature	Date	Parent/Guardian Authorizing Care
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Pathways Chiropractic & Wellness

Dr. Bethany Holwegner-Dr. Ryan Koch

2600 Gateway Ave., Suite 2

Bismarck, ND 58503

Informed Consent for Chiropractic Care

When a patient seeks chiropractic 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 chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) 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.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic 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 chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name

Signature

Date

Consent to evaluate and adjust 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 chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature

Date

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:** _____

INSURANCE VERIFICATION FORM

Patient Name: _____ DOB: _____

Insured Name: _____ ID #: _____

Insurance Phone #: _____ Group #: _____

Claim address or Payer ID #: _____

Personal Injury ONLY:

Claim #: _____ Adjuster: _____ Ext: _____

BENEFITS

Effective Date: _____ Deductible: _____ How Much Met? _____

Percent Covered: _____ % Is this based on usual and customary charges? _____

Is there a co-pay? _____

CYM? _____ Is this per condition or per calendar year? _____
(calendar year max)

When does the calendar year begin? _____ \$ Limit per policy: _____

NOTES:

VERIFICATION INFORMATION

Insurance Verified by: _____

Date Verified: _____