Dr. Russell T. Morter, DC
Dr. Lauren Newton Morter, DC
www.intouchhealthnwa.com
intouchhealthnwa@yahoo.com

InTouch Health

In touch with self. In touch with source.

101 S. 3rd St.
Rogers, AR 72756
479.621.0480

Practice Member Registration

Patient's Legal Name: _____Preferred Name_____ Date: _____

Birth date: _____ Age: _____ Sex: M F

Marital Status: Married Single Divorced Widowed Separated

Phone No:_____ Email Address: _____

Where do you prefer to be contacted for appointments? ____ Call ____ Text Message ____ Email

May we periodically email you regarding the following: ____ Yes____ No ____ events/specials ____ monthly newsletters

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____ Phone No: _____

Emergency Contact Info

Name:_____ Relationship to Patient: _____ Phone No: _____

How did you hear about us? ____Friend/Family ____Physician/Midwife Referral ___Internet/Google ___Facebook

__Event _____ ____Phone Book ___Close to home/work ___Other_____

Person who referred you: _____

Spouse Information

Spouse's Name: _____ Spouse's Phone: _____

Do you have any children? Yes No How many and their ages? _____

Chief Health Concern (reason you are here):

_____

Previous treatments for this concern:

_____

Is this condition interfering with your:

___Work ___Family ___Sleep ___Daily Routine ___Sports/Activities ___Quality of Life Other: _____

What other health practitioners you have seen?

___Chiropractor ___MD ___Naturopath ___Physiotherapist ___Massage therapist___ Other: ____

Are you currently under the care of a physician or other health care professionals? ___Yes ___No

(If yes, please give name & date of last visit): _____

Other complaints or concerns: _____

_____

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Vitality Questionnaire

Overall Health (circle one): Excellent / Good / Fair / Poor / other: _____

What is your level of commitment to yourself, your life, and your well-being? ___ High ___ Medium ___ Low

Check the phrase(s) that most represent your approach to your health & lifestyle:

I make choices based on: __ Crisis/symptoms __ Preventing problems __ Improving health & quality of life

Any falls, injuries, car accidents, surgeries, etc. we should know about?

_____

Current medications / drugs being taken:

_____

Nutritional supplements you are taking:

_____

Do you smoke, drink coffee or alcohol? (if yes indicate how much per wk/mo.)

Cigarettes _____ Coffee _____ Alcohol _____

Any family history of illness (circle those that apply): Cancer / Diabetes / Heart Disease / Arthritis / Other

_____

Any Family Pets or animals you are around regularly: _____

Are you interested in learning about Animal B.E.S.T.? ___Yes ___No

Are you interested in completing a Nutrition Symptom Survey and Dietary & Exercise Log? ___Yes ___No

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Check all symptoms you have experienced **within the past six months:**

Constitutional
O Weight Loss
O Neck Pain
O Fatigue
O Fever

Eyes
O Glasses/Contacts
O Eye Pain
O Double Vision
O Cataracts

Ear, Nose, Throat
O Difficulty Hearing
O Ringing in Ears
O Vertigo
O Sinus Troubles
O Congestion/Stuffiness
O Sore Throat

Cardiovascular
O Murmur
O Check Pain
O Palpitations
O Dizziness

Endocrine
O Loss of Hair
O Heat/Cold Intolerance
O Difficulty Sleeping
O Chronic Fatigue
O Run down

Respiratory
O Cough
O Numbness in Hands or Arms
O Coughing Blood
O Wheezing
O Chills

Gastrointestinal
O Heartburn/Reflux
O Nausea/Vomiting
O Constipation
O Diarrhea
O Bloating
O Abdominal Pain
O Black/Bloody Stool

Genitourinary
O Burning/Frequency
O Nighttime
O Blood in Urine
O Erectile Dysfunction
O Abnormal Discharge
O Bladder Leakage

Allergic/Immunologic
O Hives/Eczema
O Hay Fever

Neuro-Emotional
O Anxiety/Depression
O Mood Swings
O Worrier
O High Stress
O Poor Memory

Hematology/Lymph
O Easy Bruising
O Heart Attack
O Gums Bleed Easily
O Enlarged Glands

Musculoskeletal
O Joint Pain/Swelling
O Stiffness
O Muscle Pain
O Back Pain
O Weakness

Skin
O Psoriasis
O Rash/Sores
O Lesions
O Itching**/**Burning

Neurological
O Loss of Strength
O Numbness
O Headaches
O Tremors
O Memory Loss
O Loss of Coordination/Balance

Females only
Age Onset Periods_____
Age Onset Menopause_____
Regular Periods? Y N
Number of Pregnancies_____
O Persistent Vaginitis
O PMS
O Birth Control use
Type of BC _____
Years used _____

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Thank you for choose InTouch Health for your health care needs! It is our mission to continue to enhance your active lifestyle through affordable Chiropractic care and Wellness products. Our goal is to provide an opportunity for everyone to improve their quality of life through affordable Chiropractic care.

FINANCIAL POLICY

Payment is expected at the time of service. We accept cash, check, or credit cards as payment.
Dr. Russell Morter does **NOT** accept or file **ANY** health insurance. If you have been involved in a motor vehicle accident or if you would like to file to BlueCross Blue Shield, you may only schedule with Dr. Lauren Morter.

Initial visits are **$75.00**. Established patient visits are **$47.00** per person. Children, 17 years and younger, living at home with parent/guardian are **$30.00** per service per person. If you are filing with insurance there is **15%** fee per service to bill a third party. All refunds are based on the single visit fee ** Visits not paid at the time of service will receive a 15% fee**

Services Offered: Chiropractic Adjustment, B.E.S.T. Treatment (Bio-Energetic Synchronization Technique), Mechanical Traction, Electrical Stimulation, Therapeutic Exercise, Manual (soft tissue) Therapy, Kinesiotaping, Nutritional Consultation, Lab work, Animal B.E.S.T.

Terms of Acceptance

When one seeks chiropractic health care and is accepted for such care, it is essential for both to be working towards the same objective. Chiropractic has one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
Adjustment: The specific application of forces to facilitate the body's correction of Subluxation.
Subluxation: A misalignment of one or more joints of the 170 joints of the body which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum potential.

We do not offer to diagnose or treat any disease or condition other than interference to the nervous system and subluxation. However, if during the course of a chiropractic evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area and refer you as needed.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Two or more similar conditions may respond differently to care. Though chiropractic adjustments and other physiotherapies usually are beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to: fractures, disc injuries, strokes, dislocations and sprains. It is the responsibility of the patient to make it known or learn from healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention to the Doctor of Chiropractic.

I, _____have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I understand that any nutritional counseling is strictly a recommendation. I therefore accept care on this basis.

_____ _____
Signature Date

Consent to evaluate and give care to a minor

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive care. I understand that any nutritional counseling is strictly a recommendation

_____ _____
Parent/Guardian Signature Date