Confidential Patient Information

Dr. Russell T. Morter, DC
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InTouch Health

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In touch with self. In touch with source.

Adult Practice Member Registration

Patient's Legal Name: ________________________________Preferred Name____________________ Date: __________

Address: ____

City: _______________________ State: ___________ Zip Code: _______________________

Phone No:_________________________________ Email Address: ____________________________________

Birth date: _______________ Age: ______ Sex: ☐M ☐F Marital Status: ☐Married ☐Single ☐ Divorced ☐ Widowed ☐Separated

Spouse's Name: ___________________________________ Spouse's Phone: _________________________________

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

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

Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Retired ☐Unemployed Occupation:__________________

Employer:_____________________ Phone No: ______________________

Occupation: _____________________ Employer: ______________________________ Phone No: ______________________

Emergency Contact:__________________________ Relationship to Patient: __________Phone No: _______________________

How did you hear about us? ☐Existing Practice Member________________ ☐Physician/Midwife Referral _________________

☐Friend/Family________________ ☐ Internet/Google ☐Social Media___________ ☐Website______

☐Event ___________ ☐Close to home/work ☐ Other__________________

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

Authorization of Release

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me. I understand that you do not bill insurance companies directly, but I authorize the release of my information should I choose to seek reimbursement.
2. I acknowledge that my health-related information may be shared with other providers for my benefit and fully authorize you or another provider to exchange this information as necessary; this includes, but is not limited to: diagnostic imaging, patient records, and/or any pertinent health-related information.

Patient Signature:_____________________________________ **Date:**_____/______/___________

Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

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Case History

Reason(s) for utilizing our care: Relief of pain/symptoms Preventing further problems Improving overall health & wellness

Chief Health Concern (reason you are here): _________________________ When did this begin?___________________

How did your symptoms begin? (i.e. Lifting, ect.)____

In the past, have you experienced similar symptoms? ☐Yes ☐No Please explain____

Severity (10 is worst): 1 2 3 4 5 6 7 8 9 10 Timing: Constant / Intermittent / Daytime / Nighttime

Quality of Pain: Numb/Ache/Sharp/Dull/Stiff/Tight/Other: ____

Does the pain radiate? ☐Yes ☐No Where: ____

Circle any other symptoms that you may experience:

Headaches	Numbness in Arms	Tension
Neck Pain	Numbness in Legs	Irritability
Neck Stiffness	Difficulty Standing	Anxiety
Back Pain	Difficulty Sitting	Depression
Back Stiffness	Difficulty Bending	Insomnia
Pins & Needles Arms	Difficulty Walking	Dizziness
Pins & Needles Legs	Difficulty Lifting	Nausea/Vomiting

Does anything make it better? __________________________________ Does anything make it worse? _________________________________

Is this condition interfering with your ☐Work ☐Family ☐Sleep ☐Daily Routine ☐Sports/Activities ☐Quality of Life ☐Other: ___________

Are you allergic to any medication? ☐Yes ☐No What kind? ____

Are you currently taking medication? ☐Yes ☐No What kind? ____

Are you currently taking any nutritional supplements? ☐Yes ☐No What kind? ____

Are you pregnant? ☐Yes ☐No How many weeks? ____

Previous treatments for this concern or in past 6 months: ____

Other Health Practitioners you have seen or are currently seeing (Please Provide their names, contact info, & date of last visit if possible):
☐ Chiropractor _______________________________________ ☐ MD____
☐ Naturopath __________________________________ ☐ Physical therapist_____________________________________
☐ Massage therapist_____________________________ ☐ Other: _______________________________________

Are you currently under the care of a physician or other health care professionals? ☐Yes ☐No

Physician: ________________________ City: _________________State:_______ Phone______________Est. Date of Last Visit: _______________

Previous Chiropractic Care: ☐Yes ☐No If Yes, for what Problem: ____

Chiropractor's Name/Location ____

Have you been in the hospital or had surgery for any reason? ☐Yes ☐No If Yes explain:____

Have you ever been in an accident? ☐Yes ☐No If Yes explain:____

Do you smoke? ☐Yes ☐No If Yes how much/when did you quit?____

Do you consume alcohol more than socially?☐Yes ☐No Avg. number of drinks per week: ____

Do you exercise? ☐Yes ☐No What is your routine?____

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FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses (Cancer, Diabetes, Heart Disease, Arthritis, Other) If deceased, from what?

Mother:____ Father:____

Brother(s):____________________________________ Sister(s):____

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
O Other

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
O Spotting
O PMS/ Cramps/Painful Menses
O Itching
O Painful Intercourse
O Hot Flashes
O Oral Contraceptive Use
O Birth Control Shot
O IUD
O HPV Shot

Females Only: Please give a brief overview of your menstrual cycle (ex. Age of Onset, Regularity, Avg # of days you bleed, cycle length, light/mod/heavy, mood swings, types of birth control used and length of time used):____

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Informed Consent

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions of the patient. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of a Vertebral Subluxation Complex (VSC). When VSCs are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no Doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether you should take this step, but you are responsible for the final decision.

INFORMED CONSENT TO CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The Doctor, of course, will not give a Chiropractic adjustment if he/she is aware that such care may be contraindicated. Again, 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. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic services is to promote natural health through reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions that do not respond to Chiropractic care, may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the Doctor **BEFORE** signing the Consent to Treat

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.

Patient 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

Guardian Signature: ____ Date: _________________________

Doctor Signature: ____ Date: ____________________________