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

Pediatric Practice Member Registration

Child's Full Name:_____ Preferred Name :_____Date:_____

Mother's Full Name:_____ Father's Full Name:_____

Address:_____ City/Town:_____ State: _____ Zip: _____

Mother's Phone:_____Father's Phone:_____Email: _____

Mother's Occupation:_____ Father's Occupation:_____

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

Birth Date: ____/____/____ Birth Weight: _____ Birth Length: _____

Age:_____ Sex: M F Current Weight:_____ Current Length: _____

No. of Siblings & Ages:_____

In Case of Emergency Contact: (Local Friend or Relative, not living at same address)

Full Name:_____ Relationship to Patient:_____

Work Phone #:_____ Cell Phone #:_____

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: _____

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: _____

_____

Medications: _____

Surgeries: _____

Accidents: _____

Relevant Family History: _____

Previous chiropractic experience: _____

Any other information we should know? _____

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Developmental History: At what age did the child: Hold Head Up_____ Push-up to Hands_____ Roll Over_____

Sit Unassisted_____ Stand_____ Crawl_____ Walk with Assistance_____ Walk without Assistance_____

Childhood Health History: Circle All That Apply

Allergies	Concussion	Heart Problems	Polio
Anemia	Convulsions	Hernias	Rheumatic Fever
Arthritis	Diabetes	Hyperactivity	RSV
Asthma	Diarrhea	Measles	Rubella
Backaches	Digestive Disorders	Multiple Sclerosis	Scarlet Fever
Bed Wetting	Dizziness	Mumps	Sinus Trouble
Behavioral Issues	Ear Infections	Muscular Dystrophy	Skin Issues (Eczema, Hives, Rash)
Broken Bones	Epilepsy	Nervousness	Stomach Aches
Chicken Pox	Fainting	Neuritis	Tuberculosis
Constipation	Growing Pains	Numbness	Whooping Cough

Are you currently following the CDC recommended vaccine schedule: ___Yes ___ No ___ Delayed

Immunizations Received(if different from CDC rec.) _____

Birth History

Type of Birth: Vaginal_____ Forceps_____ Breech_____ Scheduled Cesarean_____ Emergency Cesarean_____ Home_____ Birthing Center_____ Hospital_____

Was there presence at birth of: _____Jaundice (yellow) _____Cyanosis (blue) APGAR Score:_____

Problems during Pregnancy:_____

Problems during Labor/Delivery:_____

Congenital Anomalies/Defects: _____

Infant Feeding & Length of Time: _____Breast ____Bottle ___Formula Brand: _____

Does the child consume any of the following: Dairy Wheat Meat Artificial Flavors Artificial Colors Soy Processed

Nutritional Supplements _____

No. of Hours Sleep per night: _____ Quality of Sleep: _____Good _____Fair _____Poor

Obstetrician/Midwife: (name)_____ (location)_____

Pediatrician/Family MD: (name)_____ (location)_____

Date of last visit to MD:_____ Purpose:_____

Has your child ever been treated on an emergency basis? Y N Describe:_____

Any household pets or other animals you or family members are in close contact with: _____

_____

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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.

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