Confidential Patient Information
Dr. Russell T. Morter, DC
Dr. Lauren Newton Morter, DC
www.intouchhealthnwa.com

InTouch Health

In touch with self. In touch with source.

101 S. 3rd St.
Rogers, AR 72756
479.621.0
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Postpartum 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 & 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:**_____/_____/_____

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Chief Health Concern(s):

Since having your baby, what is your Chief Health Concern: _____

Any Previous Treatment for this Concern: _____

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: _____

Please Check Any Concerns That Apply: ____Diastasis Rectus Abdominis ____Urinary Incontinence
____Pelvic Floor Dysfunction/Weakness ____Lower Back Pain or Discomfort
____Groin and/or Pubic Area Discomfort ____Difficulty w/ Breastfeeding/Milk Production
____Other_____

What other concerns do you have now? ____Sleep ____Household Duties ____Finances ____Work/Career
____Health of Child(ren) ____Current Relationship(s) ____Healthcare Team ____Opinions of Family/Friends
____Other_____

Recent Birth Experience

Was this your first pregnancy? ____Yes ____ No

If not, please tell us about your previous pregnancy and/or birth experience(s). (*Duration, interventions, etc.)*

_____
_____

Was this pregnancy planned or unexpected? _____

Did you have any difficulty conceiving? ____Yes ____ No

If yes, please explain: _____

How many weeks gestation were you are the time your most recent birth? _____

Type of Birth: _____ Vaginal _____ Forceps _____ Breech _____ Scheduled Cesarean

_____Emergency Cesarean _____Home Assisted _____Home Unassisted _____ Birthing Center _____ Hospital

Any complications or problems during Pregnancy? _____

Any complications or problems during Labor/Delivery? _____

Was your desired birth plan respected, followed, and accomplished? ____Yes ____ No

Please, explain: _____

How do you feel overall about your birth experience? (check all that apply)

____ Happy ____Content ____Proud ____Conflicted ____ Sad ____Hurt ____Numb ____Other

Feel free to elaborate_____

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Current Health Status (Physical, Chemical & Emotional/Mental Stress)

Have you had a menstrual cycle since giving birth? How many weeks postpartum? _____

Briefly describe your period/cycle (length, light/heavy, cramping, etc.): _____
_____

Have you used any form of hormone or oral contraceptive? (birth control) ___Yes ____No ____ Past ____Present

If yes, which ones and for how long? _____

Have you experienced hemorrhoids, headaches, dizziness, carpal tunnel syndrome, or other uncomfortable symptoms? (please explain) ____Yes ____ No Please explain: _____

Late Pregnancy Weight: _____ Current Weight: _____

How your feel about your weight since having a baby: _____

What types of exercise(s) and/or stretches are you performing? _____

_____

Would you like additional support in developing a healthy postpartum exercise routine/program? ____Yes ____ No ____ Unsure Feel free to elaborate to help us better support you: _____

Please tell us about your current diet and any dietary restrictions:_____

_____

Do you feel like you are eating throughout the day? ____Yes ____ No ____Unsure Avg # ounces water per day:_____

Are you taking any medications or nutritional supplements? ____Yes ____ No

If yes, please explain: _____

Have you had any slips, falls, hospitalizations, or other physical traumas recently or during the pregnancy?

____Yes ____ No If yes, please explain: _____

Any major emotional stressors during your pregnancy? ____Yes ____ No

If yes, please explain: _____

Has another health care provider had you fill out an Edinburgh Postnatal Depression Scale (EPDS)? ____Yes ____ No

Do you plan on breastfeeding your child? ____Yes ____ No

Please explain: _____

Please list any concerns or questions you have regarding breastfeeding or formula feeding: _____

_____

What do you intend to do about vaccinations? _____

Anything else you would like to tell us about your pregnancy or birth plans? _____

_____

What are your expectations of us as your Chiropractors? What would you like to gain from your experience here?

_____

Please list anything else you would like to tell us about your pregnancy, birth, or postpartum experience here:

_____

_____

Do you have any questions you would like to be sure are asked/answered today? _____

_____

_____

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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 Balance

Females only
O Spotting
O PMs/Cramps/Painful
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: _____