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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Pregnant 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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Dear Practice Member: 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

Previous Birth Experience(s)

Is this your first pregnancy? ____Yes ____ No

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

_____

Do you plan to follow a similar plan to your previous delivery? ____Yes ____ No

Please, explain: _____

Conception & Early Pregnancy

When was your last menstrual cycle? _____

How far along are you & what is your estimated due date? _____

Do You know if you are having a boy or girl, or will it be a surprise? _____

Did you have any difficulty conceiving? ____Yes ____ No

If yes, please explain: _____

Have you ever used any form of hormone or oral contraceptive? ____Yes ____ No

If yes, which ones and for how long? _____

What was your pre-pregnancy weight? _____ Current Weight: _____

Have you experienced morning sickness, heart burn, constipation or other uncomfortable symptoms? ____Yes ____ No

If yes, please explain: _____

Current Health Status

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

_____

What is your current diet like? Any restrictions? _____

_____

Have you taken any medications or supplements during pregnancy? ____Yes ____ No

If yes, please explain: _____

Have you experienced any slips, falls, or other traumas during this pregnancy? ____Yes ____ No

If yes, please explain: _____

Any major emotional stressors during your pregnancy? ____Yes ____ No

If yes, please explain: _____

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Your Birth Plan

Your top three goals for your pregnancy:

1. _____

2. _____

3. _____

Do you currently have a birth plan? ____Yes ____ No

If yes, please explain: _____

Are you taking any prenatal or birthing classes? ____Yes ____ No

If yes, please explain: _____

Who is your OB/GYN or Midwife? _____ Will they be present for delivery? ___Yes ____ No

Do you intend to have a doula or birth coach present? ____Yes ____ No

If yes, please explain: _____

Do you plan to have a vaginal delivery? ____Yes ____ No

If yes, please explain: _____

After 32 Weeks Gestation

Position of the baby: ____Head down ____ Breech ____ Posterior ____ Unknown

Confirmed By: ____Ultrasound ____ Palpation (felt with hands)

Post-Birth Plan

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 would you like to gain from our care during your pregnancy? _____

_____

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

_____

_____

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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 ☐ Routine ☐ 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 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: _____

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?_____

Please circle regular dietary intake: fruits veggies meats grains dairy nuts/seeds sugars Paleo/Primal gluten-free

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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):_____

Other:_____ Other:_____

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: _____