welcome to morterwellness

Your Name:

Address ____City __________________ State _____ Zip __________

Home Phone _______________ Work Phone _________________ Cell Phone ___________________________

Email address ________________________________May we add you to our e-mail list? Yes ___ No____

Age _________Birth Date ______________ Sex ____ Marital Status ________ # of Children _________

Who may we thank for referring you to Morter Wellness Center? ____

People consult Morter Wellness Center with varied health objectives. Please check below those that apply to you.

- ☐ Relief of symptoms
- ☐ Correction of my underlying problem
- ☐ Better perform work or recreational activities
- ☐ Improve my health and enhance my quality of life
- ☐ Maximize my own, my family's and my community's health

PRESENT MEDICAL HISTORY

Purpose of today's visit:____

Date symptoms appeared or accident happened:____

Is present illness s due to: ☐Auto ☐Work ☐Illness ☐Unknown ☐Other (describe)_____________________

Have you ever had the same or a similar condition? ☐Y ☐N If yes, when:___________________________ Days lost from work:__________________________ Last physical exam (date):__________________________

Describe each PAIN or SYMPTOM that you are having and **place ☐☐ on the SEVERITY OF PAIN SCALE** to indicate the level of discomfort that the pain/symptom creates. **1 = No pain** and **10 = Worst pain ever.**

PAIN or SYMPTOM DESCRIPTION:	**SEVERITY OF PAIN SCALE:**
1.____	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
2.____	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
3.____	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Symptoms occur in: __ ☐Morning ___☐Afternoon __☐Night ____☐Consistently ☐___ Come & Go ___☐Other

Symptoms have persisted for (number): ____Hours ____Days ____Weeks ____Months ___Years

Check the following activities that **AGGRAVATE YOUR CONDITION:**

☐___Bending ☐___Coughing ☐ ___Lifting ☐___Lying ☐___Reaching ☐___Sitting ☐___Sneezing
☐___Standing ___Turning Head ___Walking ☐ ___Straining at Stool ☐Other______________________

Check the following activities that **RELIEVE YOUR CONDITION:**

☐___Bending ___Lifting ☐___Lying ___Reaching ☐___Sitting ☐___Standing ☐___Turning Head
___Walking ☐___Stretching ☐ ___Cold Pack ☐ ___Hot Pack ___Self Massage ☐Other_____________________

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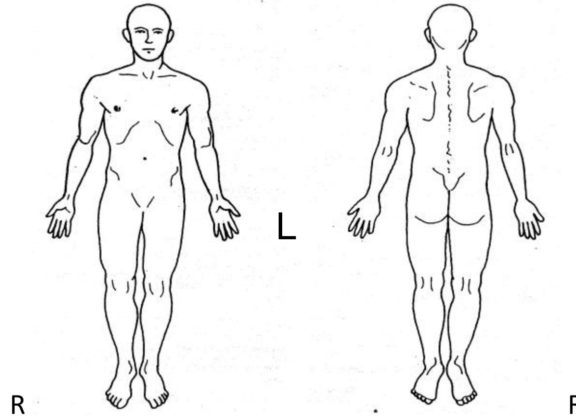
Your Name:

PAIN DRAWING: Mark your painful spots on the picture. If your pain radiates, draw an arrow from where it starts to where it stops. Use the appropriate symbols to describe the pain.

Ache > > > **Burning x x x** **Numbness = = =** **Pins/Needles o o o** **Stabbing / / /** **Throbbing ~ ~ ~**



STRESS

Do you feel that stress contributes to your pain? ____

If so, how? ____

How often do you find yourself stressed?

☐ a little ☐ most of the day ☐ 24/7 – constant

What is the reason for your stress?

☐ family ☐ job ☐ worrying ☐ pain ☐ politics ☐ fear ☐ past emotional trauma ☐ anger

☐ other:____

SLEEP

How well do you sleep at night? ☐ Good (7+ hours) ☐ Alright (5-6 hours) ☐ Terrible (< 5 hours)

Do you have difficulty falling asleep? ☐ All the time ☐ Sometimes ☐ Never

Do you wake up in the middle of the night? ☐ All the time ☐ Sometimes ☐ Never

WATER

How much water do you drink daily? (Best guess in ounces) _______________________

What are your health objectives?

____

Name of the last doctor who put you on a wellness program? ___________________________________

Were you able to stay on the program? ______ How long? ____________

What were your results? ____

welcome to morterwellness

Your Name:

INSURANCE INFORMATION

How will you be paying for today's visit? ☐___Cash ☐___Check ___Credit Card

Please check all insurance coverage that may be applicable in this case**:**

___Major Medical ☐___Auto Accident ☐___Worker's Compensation ☐___Medicare ___Flex Plans ☐Other__________

Health Insurance Patients: *We will file Blue Cross/Blue Shield insurance for our patients. Our policy is to collect full payment from the patient until insurance is verified. **If we have a copy of your insurance card, you may skip this section.

Insurance Carrier Name____

Group #__________________________________ Policy #_______________________________________

Is the insurance policy in your name? ☐Y ☐N (**If No**, please fill out the following for the insured)

Insured's First Name________________________ M.I.________ Last Name________________________

Insured's Address___________________________ Unit #________ City_____________________________

State________ Zip________ Insured's Birth Date (mm/dd/yyyy)________________________ Sex: ☐M ☐F

Insured's Social Security #___________________ Your relation to the Insured________________________

Auto Accident & Worker's Compensation Patients: Type: ☐Auto Accident ☐Worker's Compensation

Insurance Carrier Name____

Insurance Carrier Address____

Insurance Carrier City, State, Zip____

Date of Injury______________________________ Claim Number___________________________________

Adjuster's Name____________________________ Adjuster's Telephone (______)______________________

This is about the HEALTH HISTORY of you and/or your family. Please mark each category accordingly.

You	Your Family		You	Your Family		You	Your Family	
☐	☐	Alcoholism	☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Anemia	☐	☐	Kidney Disease	☐	☐	Suicide Attempt
☐	☐	Asthma	☐	☐	Liver Disease	☐	☐	Thyroid Disease
☐	☐	Cancer/Tumor	☐	☐	Hepatitis	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Lung Disease	☐	☐	Digestive Issues
☐	☐	Drug Abuse	☐	☐	Mental Illness	☐	☐	Venereal Disease
☐	☐	Depression	☐	☐	Osteoarthritis	☐	☐	High Cholesterol
☐	☐	Epilepsy/Seizures	☐	☐	Osteoporosis	☐	☐	HIV
☐	☐	Glaucoma	☐	☐	Phlebitis	☐	☐	Heart Disease
☐	☐	Rheumatoid Arthritis	☐	☐	Autoimmune	☐	☐	Other______________

Past Surgical History (Please include dates):

____

____

Current Medications: Include Birth Control Pills, Vitamins, and Supplements. Medicine name & reason taking:

____

____

____

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Your Name:

Allergies

____

____

This section is about symptoms you have personally experienced ***within the past six months***. Please check any that apply.

CONSTITUTIONAL	**RESPIRATORY**	**HEMATOLOGY/LYMPH**
☐ Weight Loss	☐ Cough	☐ Easy Bruising
☐ Fatigue	☐ Coughing Blood	☐ Gums Bleed Easily
☐ Fever	☐ Wheezing	☐ Enlarged Glands
☐ Chills	**MUSCULOSKELETAL**	
EYES:	☐ Joint Pain/Swelling	**GASTROINTESTINAL:**
☐ Glasses/Contacts	☐ Stiffness	☐ Heartburn/Reflux
☐ Eye Pain	☐ Muscle Pain	☐ Nausea/Vomiting
☐ Double Vision	☐ Back Pain	☐ Constipation
☐ Cataracts	☐ Headache	☐ Change in BMs
EAR, NOSE, THROAT:	☐ Stress	☐ Diarrhea
☐ Difficulty Hearing	☐ Allergy	☐ Abdominal Pain
☐ Ringing in Ears	☐ Muscle Tension	☐ Black or Bloody BM
☐ Vertigo	☐ Frontal	☐ Itching/Burning
☐ Sinus Issues	☐ Occipital (Back of head)	**SKIN:**
☐ Nasal Stuffiness	☐ Shoulders or Arms	☐ Jaundice
☐ Frequent Sore Throat	☐ Pelvis, Hips, Knees, Feet	☐ Rash/Sores
CARDIOVASCULAR:	☐ TMJ Issues	☐ Lesions
☐ Murmur	**GENITOURINARY:**	**NEUROLOGICAL:**
☐ Chest Pain	☐ Burning/Frequency	☐ Loss of Strength
☐ Palpitations	☐ Nighttime	☐ Numbness
☐ Dizziness	☐ Blood in Urine	☐ Fuzzy Thinking
☐ Fainting Spells	☐ Erectile Dysfunction	☐ Tremors
☐ Shortness of Breath	☐ Abnormal Discharge	☐ Memory Loss
☐ Difficulty lying Flat	☐ Bladder Leakage	
☐ Swelling Ankles	**ALLERGIC/IMMUNOLOGIC:**	**FEMALES ONLY:**
PSYCHIATRIC:	☐ Hives/Eczema	Age Onset Periods_____________
☐ Anxiety/Depression	☐ Hay Fever	Periods Regular? Yes_____No____
☐ Mood Swings	**ENDOCRINE:**	Age Onset Menopause___________
	☐ Loss of Hair	# of Pregnancies_____________
	☐ Heat/Cold Intolerance	

Signature of Reviewing Physician____

Date:____

welcome to morterwellness

Your Name:

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to this chiropractic office. I authorize the doctor to release all information necessary to communicate with personal healthcare providers, payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

MISSED APPOINTMENT / CANCELLATION POLICY: We make every effort to accommodate your scheduling needs. In return we ask that you keep your scheduled appointments or notify us in advance if for any reason you are unable to keep your appointment. We request a 24 hour notice in order to reschedule or cancel your appointment. A $25 fee will be charged if you miss or cancel your appointment without a 24 hour notice. The missed appointment fee is NOT covered by insurance and is your responsibility to pay.

Patient Name (Print):___________________________ Date:____

Patient Signature:_____________________________

welcome to morterwellness

Your Name:

INFORMED CONSENT AND AUTHORIZATION TO TREAT

Please read and sign the informed consent. This must be read and signed prior to the doctor performing an examination. If you have any questions or concerns, please address them to the doctor.

CHIROPRACTIC:

Doctors of Chiropractic (D.C.) who use manual therapy techniques such as spinal adjustments are required to advise patients that there may be some risks associated with such treatment. While Morter Wellness Center does not employ traditional methods of Chiropractic that involve twisting of the neck or back, you need to be aware of risks associated with Chiropractic care.

a) While rare, some patients have experienced rib fractures, or muscle and ligament strains or sprains following spinal adjustments.

b) Some types of spinal adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement within and without the profession, with prominent authority saying that there is at most a one-in-a-million chance of such an outcome. We employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. At Morter Wellness, we use techniques that do NOT employ twisting the neck.

c) There have been rare reported cases of disc injuries following neck or low back adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches and other symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

PLEASE INITIAL AFTER READING _____

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor feels at the time, based upon the facts then known, are in my best interests. I understand that the results are not guaranteed. I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of the chiropractic treatment (may include spinal adjustments) as well as the contents of this Consent. I consent to the treatments recommended to me by my chiropractor.

Patient Name (Print):___________________________ Date:____

Patient Signature:_____________________________

welcome to morterwellness

Your Name:

FINANCIAL POLICY FOR PATIENTS WITH HEALTH INSURANCE

Morter Wellness Center is "In-Network" with Blue Cross/Blue Shield only. All other insurance plans are considered "Out-of-Network".

"In-Network" Insurance Plans: All co-payments, co-insurance, deductibles and non-covered services are due at the time of service. We will submit a claim one time on the patient's behalf. You are responsible for payment of all services your insurance company may deny or fail to pay.

"Out-of-Network" Insurance Plans: Payments for all services are due in full at the time services are provided. Morter Wellness Center is under no obligation to pursue reimbursement on the patient's behalf.

CREDIT GUARANTEE FOR "IN-NETWORK" INSURANCE PLANS ONLY

As the recipient of services from Morter Wellness you are ultimately responsible for payment for all services provided. In order for our office to bill your Insurance Plan, as a prerequisite, we ask that you provide a credit card on our security file to guarantee payment of your bill. Our office will submit a claim one time to your listed Health Insurance Provider. It is your responsibility to ensure that your health insurance pays your bill. If payment is not received in full within forty five (45) days after submission, by providing your credit card to be stored on our security file and by receiving provided services, you are authorizing Morter Wellness Center to charge your credit card for any unpaid bills or claims. Any claims paid after your credit card has been billed will be refunded to the patient. If your credit card becomes expired or is replaced due to fraudulent activity, it is your responsibility to inform us of your new card number immediately. If you choose not to leave a credit card on file, payment is due IN FULL AT THE TIME ALL SERVICES ARE PROVIDED.

PLEASE INITIAL AFTER READING ________

AUTHORIZATION (to release information & settle appeals or disputes) and ASSIGNMENT (of benefits to doctor)

I hereby authorize the doctor to release all medical information necessary to process any insurance claims. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the listed Health Insurance Provider, and hereby assign and convey directly to Morter Wellness Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

PLEASE INITIAL AFTER READING _________

Patient Name (Print): ______________________________________ Date: _____________________________

Patient Signature: ____