MARCIE MORTON, DC - HELIOS NATURAL HEALTHCARE
marcie.s@me.com (415) 728-5791

CONDITIONS OF PATIENT INTAKE & CONSENT FOR CHIROPRACTIC TREATMENT

PATIENT NAME: _____

To the patient – Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Consent to Treatment. I consent to the procedures which may be performed while under care of Dr. Marcie Morton, including chiropractic manipulative therapies, soft tissue modalities, core stabilization and flexibility exercises, and lifestyle and nutritional assessment and advice. If my condition falls outside of the scope of this clinic, I will be referred to the appropriate medical specialist for further evaluation and treatment. If an emergent medical concern is to arise while I am in this clinic, 911 emergency services will be called on my behalf.

- *The nature of the chiropractic adjustment*. The primary treatment used by a Doctor of Chiropractic (DC) is chiropractic manipulative therapy. This procedure will be used for your treatment, and may include use of hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.
- *Analysis/Examination/Treatment*. As a part of the analysis, examination and treatment, you are consenting to the following procedures: chiropractic manipulative therapies, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis, ultrasound, heat/cold therapy, electrical stimulation and radiographic studies.
- *The material risks inherent in chiropractic adjustment*. As with any healthcare procedure, there are certain complications that may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Every reasonable effort will be made during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to Dr. Morton's attention, it is your responsibility to inform her.
- *The probability of those risks occurring*. Fractures are rare occurrences and generally result from some underlying weakness of the bone, a risk factor that will be evaluated during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.
- *The availability and nature of other treatment options*. Other treatment options for your condition may include self-administered over-the-counter analgesics and rest; medical care and prescription drugs (such as anti-inflammatory, muscle relaxants and pain-killers); hospitalization; surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options that you may wish to discuss these with your primary medical physician.
- *The risks and dangers attendant to remaining untreated*. Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction that further reduces mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

American with Disabilities Act. This office building is not fully compliant with the Americans with Disabilities Act. For that reason, home visits are offered at no extra charge.

Financial Agreement. This is an insurance-free practice, which means that payment is collected in full at the time of each visit. At your request, you will be provided with a super bill, which you can submit to your carrier for reimbursement. If your financial situation requires special arrangements, please speak with Dr. Morton.

Please understand that this clinic DOES NOT promise that an insurance company will or should pay the fees that are charged; the clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement – this is the patient's obligation; if you have more than one insurance policy and would like to bill it, please request an additional copy of our super bill for you to use in requesting reimbursement from your secondary insurance policy.

Additional Provision for Treatment of Minors. I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor patient.

Notice of Privacy Practices. I acknowledge that I have received this clinic's Notice of Privacy Practices, which describes the ways in which the clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact Dr. Morton directly if I have a question or complaint.

Acknowledge: _____ (Initial)

If you would like to receive the Notice of Privacy Practices electronically, rather than in a printed copy, please initial below.

Acknowledge: _____ (Initial)

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW. I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Marcie Morton, DC and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment, and agree to be bound by the terms if this document. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any chiropractic treatment or services.

Patient/Authorized Representative Signature: Date:

_____ _____

Please print name on line below:

_____

If you are not the patient, please identify your relationship to the patient:

_____

REVIEW OF SYSTEMS – ADULT

Please take a moment to complete the following. ***In the last 3 months*** have you experienced any of the following?

Please indicate ***Yes*** or ***No*** and ***explain*** if appropriate.

GENERAL	**Yes**	**No**	**Please explain further.**
			Do you have allergies to medications? If so, please list them and the reaction they caused.
			Recurrent fever or chills?
			Unintentional weight loss?
			Recurrent fatigue or malaise?
SKIN	**Yes**	**No**	
			Rash or skin color changes?
			Jaundice (yellowing of the skin or eyes)?
			Moles that are changing color or size?
HEENT	**Yes**	**No**	
			Headaches that are new or changing in frequency or severity?
			Hearing changes?
			Visual changes? (If yes, are you seeing an eye doctor?)
			Non-healing mouth sores?
			Swollen glands or neck lumps?
			Hoarseness?
RESPIRATORY	**Yes**	**No**	
			Cough that is chronic, produces phlegm or is changing?
			Difficulty breathing?
			Wheezing?
			Do you smoke or are you exposed to 2nd hand smoke?
CARDIAC	**Yes**	**No**	
			Chest pain or pressure?
			Shortness of breath with normal activity?
			Difficulty breathing when lying flat?
			Shortness of breath that wakes you from sleep?
			Palpitations (sensation of heart beating in your chest)?
			Swelling in the ankles?
GASTROINTESTINAL	**Yes**	**No**	
			Difficult or painful swallowing?
			Recurrent nausea or vomiting?
			Recurrent diarrhea or constipation?
			Recurrent abdominal pain or cramping?
			Bloody or black bowel movements?
GENITOURINARY	**Yes**	**No**	
			Pain with urination?
			Dark or reddish urine?
			Involuntary loss of urine?
			Decreased force of urine stream or difficulty starting urine?
			Problems achieving or maintaining erections?
MUSCULOSKELETAL	**Yes**	**No**	
			Painful joints? (If yes, which ones?)
			Swollen joints?
			Morning joint stiffness? (If yes, how long does the stiffness last?)

********** TURN OVER AND COMPLETE OTHER SIDE **********

NAME:_____ DATE:_____ PROVIDER REVIEW:_____

In the last 3 months have you experienced any of the following? Please indicate ***Yes*** or ***No*** and ***explain*** if appropriate.

NEUROLOGIC	**Yes**	**No**	
			Frequent dizziness?
			Fainting?
			Weakness in arms or legs?
			Numbness or tingling in arms or legs?
			Un-coordination or loss of balance?
PSYCHOLOGIC	**Yes**	**No**	
			Do you feel safe at home?
			Anxiety?
			Little interest or pleasure in doing things?
			Feeling down, depressed or hopeless?
			Suicidal thoughts?
			Social problems that you feel interfere with your mental or physical health?
	If you use alcohol or other recreational drugs		
			Have you ever tried to cut down or change your use?
			Have you ever been angered or annoyed by people confronting your use?
			Have you ever felt guilty about your use or consequences of your use?
			Have you ever used first thing in the morning as an "eye opener"?
INFECTIONS	**Yes**	**No**	
			Do you feel you are at risk for HIV infection?
			Have you ever been exposed to or treated for tuberculosis?
			Have you ever had a blood transfusion?
			Recurrent night sweats?
			Sexually transmitted diseases?
ENDOCRINE	**Yes**	**No**	
			Frequent urination? (If yes, how many times do you get up at night to urinate?)
			Increased thirst?
			Skin, hair or fingernail changes?
			Hot or cold intolerance?
GYNECOLOGIC (female)	**Yes**	**No**	
			Are you still having menstrual periods? If **YES**, when was your last menstrual period?_____ If **NO**, at what age did your periods stop?_____
			Vaginal bleeding differing from your regular menstrual flow?
			Abnormal vaginal discharge?
			Painful intercourse?
			New breast lumps?
			Abnormal pap smears? Date of last pap smear?
			Abnormal mammograms? Date of last mammogram?
PREVENTION SCREENING	**Yes**	**No**	
			Do you exercise on a regular basis (at least 3 times per week)?
			Do you believe you eat a varied, balanced diet?
			Have you had a tetanus shot within the last 10 years? If so, when?
			Have you ever had the pneumonia vaccine (Pneumovax)? If so, when?
			Have you ever had a sigmoidoscopy or colonoscopy? If so, when?
			Do you see any other doctors on a regular basis? If so, who and when?

NAME:_____ DATE:_____ PROVIDER REVIEW:_____

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REGISTRATION FORM

Section I: Patient Information Date_____

Name:_____
Address:_____
City:_____State:_____Zip_____
Phone (_____)_____ ☐ Home ☐ Work ☐ Cell Email_____
Date of Birth:_____ Employer_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Work Phone (_____) _____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____