

Mills River Family Chiropractic

Dr. Tom Gross, Chiropractic Neurologist

Dr. Laura Gross, Chiropractic Physician

www.mrchiropractic.com

4144 Haywood D., Suite 4
Mills River, NC 28759

Phone 828-891-8868
Fax 828-891-8897

Initial Child & Adolescent Questionnaire

Your Name: _____, Your Mom: _____
Your Dad: _____

Address : _____ City _____ State _____ Zip _____
Mom's Phone (Home) _____ - _____ - _____ (Work) _____ - _____ - _____ (Cell) _____ - _____ - _____
Dad's Phone (Home) _____ - _____ - _____ (Work) _____ - _____ - _____ (Cell) _____ - _____ - _____

Child's Date of Birth ____/____/____ Age: _____ Gender M F No. of Siblings _____
Birth Weight _____ lbs. _____ oz. Current Weight _____ Lbs. _____ oz.
Birth Length _____ inches Current Length _____ inches
Birth **APGAR** Score _____ Five Minute **APGAR** score _____

Mainly for Mom's:

1. Tell us about your pregnancy:

Did you carry to full term? _____
Describe any complications and when they occurred: _____

2. Tell us about your delivery and birth of this child:

	Yes	No		Yes	No
Did you use a midwife?	<input type="checkbox"/>	<input type="checkbox"/>	Hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrician?	<input type="checkbox"/>	<input type="checkbox"/>	Did you have a C- Section?	<input type="checkbox"/>	<input type="checkbox"/>
Were forceps used?	<input type="checkbox"/>	<input type="checkbox"/>	Vacuum Extraction?	<input type="checkbox"/>	<input type="checkbox"/>
Were you induced?	<input type="checkbox"/>	<input type="checkbox"/>	Did you have an Epidural?	<input type="checkbox"/>	<input type="checkbox"/>
Was it a difficult Birth?	<input type="checkbox"/>	<input type="checkbox"/>			

3. Tell us more :

	Yes	No	
Did you breastfeed?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes how long? _____
Formula?	<input type="checkbox"/>	<input type="checkbox"/>	What kind? _____
Consume Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____
Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	How much/long? _____
Exposure to ultrasound?	<input type="checkbox"/>	<input type="checkbox"/>	How many? _____

Did you take any medication during your pregnancy? Y/N
If yes, For what? And what type? _____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Fall from a changing table | <input type="checkbox"/> Frequent crying spells |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Frequent bouts of diarrhea |
| <input type="checkbox"/> Involved in car accident | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Play in Jolly Jumper | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Did not gain weight |
| <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Other |

Please explain the above: _____

5. As a young child, (5-12), did any of the following occur?

- | | |
|--|---|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fall off bike | <input type="checkbox"/> Hyperactivity / Autism |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Learning Difficulties |
| <input type="checkbox"/> Sports Accident | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> involved in a car accident | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Leg/knee pains |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Other |

Please explain the above: _____

6. Tell us about any vaccinations your child has had; _____

Any reactions to any of these? _____

Were you told that you had a choice in vaccination your child? Yes No

Would you like information on the other side of this issue? Yes No

7. As a child or adolescent, Has your child experienced any of the following;

- | | | |
|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Foot/ankle/knee pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arm/wrist pain | <input type="checkbox"/> Tingling in arms/legs |
| <input type="checkbox"/> Ringing in ear | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck/Back pains |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Shoulder pains |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> weight gain or loss | <input type="checkbox"/> Other _____ |

Please explain the above: _____

8. Which of the problems you have checked off is the worst? _____

Is this problem: Constant _____, Intermittent _____, Occasional _____, Cyclic _____

9. How long has it persisted? _____

10. When it is at its worst, how does it make your child feel? _____

11. What have you done about it that has NOT worked? _____

12. What makes it worse? _____

13. Describe any hospital stays: _____

14. Approx. how many times have antibiotics been prescribed and for what conditions? _____

15. List any and all medications it is currently taking: _____

16. Is there anything else you feel we should know? _____

17. To summarize, what is your purpose for this appointment? _____

CONSENT FOR TREATMENT OF A MINOR

I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S) TO ADMINISTER CARE THEY DEEM NECESSARY FOR MY CHILD. IT IS UNDERSTOOD THAT THE GOAL OF TREATMENT WILL BE TO ACHIEVE OPTIMUM HEALTH AND WELLNESS BY THE USE OF CHIROPRACTIC.

SIGNATURE PARENT/GUARDIAN _____ DATE _____/_____/_____

WITNESS _____ DATE _____/_____/_____

Insurance & Payment Information

Cash__ Insurance__

Responsible Party _____ Relationship To Patient _____

Primary Ins Co: _____ Secondary Inc. Co _____

Members First Name : _____ MI _____ Last Name _____

ID# _____ Group ID# _____

Ins Phone Number: _____ Members Date of Birth ____/____/____

Members SS# _____ - _____ - _____ Drivers License # _____ State _____

Employer: _____

Members Mailing Address: _____

City: _____ State: _____ Zip Code _____

Phone Number (Home) () _____ - _____ Work) () _____ - _____ (Cell) () _____ - _____

PAYMENT ARRANGEMENT

SERVICES RENDERED ARE ULTIMATELY THE RESPONSIBILITY OF THE PATIENT.

PAYMENT IS EXPECTED AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, DEBIT CARDS, MASTER CARD, VISA AND AMERICAN EXPRESS.

IF LACK OF FINANCIAL RESOURCES IS PREVENTING YOU FROM RECEIVING CARE, PLEASE TALK TO ONE OF THE DOCTORS REGARDING A TIME/PAYMENT PLAN.

PAYMENT FOR ALL LABORATORY, NUTRITIONAL SUPPLEMENTS, DURABLE MEDICAL EQUIPMENT, ORTHOTICS, OR OTHER INVENTORY STOCK IS EXPECTED AT TIME OF PURCHASE.

WE PROVIDE AN INSURANCE BILLING SERVICE AS A **COURTESY** TO OUR CLIENTS WE WILL VERIFY ELIGIBILITY OF BENEFITS AND BILL YOUR PRIMARY CARRIER FOR SERVICES RENDERED. WE WILL FILE PRIVATE/GROUP INSURANCES, MEDICARE, MEDICAID, WORKMAN'S COMPENSATION AND AUTO/ACCIDENT CLAIMS. WE ALSO PROCESS ATTORNEY CLAIMS. THIS SERVICE IN NO WAY GUARANTEES PAYMENT FROM YOUR INSURANCE CARRIER. **IF WE DO NOT RECEIVE PAYMENT, 60 DAYS AFTER FILING YOUR INSURANCE, YOU WILL BE RESPONSIBLE FOR PAYMENT AND FOR FOLLOWING UP WITH THE INSURANCE COMPANY.**

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN OBTAINING PAYMENT FROM THE INSURANCE COMPANY. ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME AND I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I TERMINATE MY CARE OR TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES AND OR INVENTORY PURCHASE BY ME WILL BE IMMEDIATELY DUE AND PAYABLE.

MISCELLANEOUS FEES

NO CALL/ NO SHOW APPOINTMENTS WILL BE SUBJECT TO A \$20.00 FEE THAT WILL NOT BE CHARGED TO ACCOUNT OR INSURANCE (other patients need an opportunity to receive help.)

ALL RETURN CHECKS ARE SUBJECT TO A \$30.00 PROCESSING FEE.

I UNDERSTAND AND AGREE TO THE ABOVE INFORMATION. I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ASSIGN AND REQUEST PAYMENT DIRECTLY TO MY PHYSICIAN.

SIGNATURE _____ **DATE** ____/____/____

WITNESS _____ **DATE** ____/____/____