Mills River Family Chiropractic

Dr. Tom Gross, Chiropractic Neurologist

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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?	☐	☐	Hospital?	☐	☐
Obstetrician?	☐	☐	Did you have a C- Section?	☐	☐
Were forceps used?	☐	☐	Vacuum Extraction?	☐	☐
Were you induced?	☐	☐	Did you have an Epidural?	☐	☐
Was it a difficult Birth?	☐	☐			

3. Tell us more :

	Yes	No	
Did you breastfeed?	☐	☐	If Yes how long?_____
Formula?	☐	☐	What kind?_____
Consume Alcohol?	☐	☐	How much?_____
Smoke?	☐	☐	How much/long?_____
Exposure to ultrasound?	☐	☐	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?

____ Fall from a changing table
____ Tumble down stairs
____ Fall out of crib
____ Involved in car accident
____ Play in Jolly Jumper
____ Frequent ear infections
____ Fall off playground equipment
____ Tonsillitis
____ Reaction to vaccination
____ Frequent crying spells
____ Frequent fevers
____ Frequent bouts of diarrhea
____ Constipation
____ Sleeping problems
____ Frequent colds
____ Colic
____ Did not gain weight
____ Other

Please explain the above:_____
_____
_____

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

____ Fall from a tree
____ Fall off bike
____ Fall off playground equipment
____ Sports Accident
____ involved in a car accident
____ Stomach pain
____ Scoliosis
____ Bed wetting
____ Hyperactivity / Autism
____ Learning Difficulties
____ Asthma
____ Allergies
____ Leg/knee pains
____ 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;

____ Headaches
____ Dizziness
____ Ringing in ear
____ Asthma
____ Hyperactivity
____ Fatigue
____ Numbness in arms/hands
____ Arm/wrist pain
____ Sleeping problems
____ Allergies
____ Stomach problems
____ weight gain or loss
____ Foot/ankle/knee pains
____ Tingling in arms/legs
____ Neck/Back pains
____ Shoulder pains
____ Growing pains
____ 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 is 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 is currently taking:_____

_____

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

_____

_____

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

_____

_____

CONCENT 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 C ode_____
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 SUPPLEMNTS , 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, MEDICADE, 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 FOLLOW-ING 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. HOW-EVER, 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 APPOINMENTS WILL BE SUBJUECT 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**_____/_____/_____

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