Mills River Family Chiropractic, P.A.

A Functional Approach to Rehabilitation, Health and Wellness

Tom Gross, DC, DACNB
Board Certified Chiropractic Neurologist

Laura Gross, DC, DAACP
Board Certified Diplomate in Chiropractic Pediatrics

Name:____________________________________ **Date:** ____________

Welcome to Mills River Family Chiropractic

History of Present Complaint

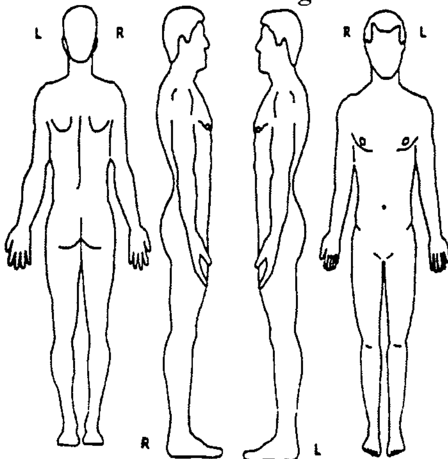
1. What is your major complaint? ____
2. Date of onset ____________ Gradual or sudden onset? ____________
3. Is this condition due to an ☐ Auto Accident ☐ Work Injury ☐ Other Accident ☐ Unknown cause ☐ Illness
4. What is the severity of pain/discomfort on a scale of 0-10 (0 is no pain, 10 is the worst you have ever experienced) ___
5. How long does an episode last approximately? ☐ Minutes ☐ Hours ☐ Intermittent ☐ Constant
6. When do you notice it most? AM/PM

5. Other complaints? Please describe: ____
6. Are the symptoms: ☐ Improving ☐ Getting worse ☐ About the same ☐ Intermittent (come and go)
7. What makes it better? ________________________ What makes it worse? ________________________
8. Type of pain: sharp dull aching burning throbbing cramping numbness tingling other : ____________
9. Have you had these symptoms before? __________ If so, when? ____________________________
10. Do you have any difficulty performing any of the following activities: (circle all that apply)

    Personal Care – Lifting – Reading – Working – Driving – Walking – Sitting – Standing – Social Life - Exercise
11. Have you seen another doctor for this condition? ____ Dr.'s Name & Location: _______________________

    Date consulted ____________ Diagnosis ________________________

Please mark areas of pain on the drawing



Family History (Please put appropriate symbol in each box that applies to family history) F = Father M = Mother S = Sister B = Brother

Diabetes	Cancer	Heart	Bld. Pres.	Chol.	Kidney	Scoliosis	Back Problems
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐

Depression	Nerves	Rheum. Arth.	MS	Psoriasis	Asthma	Thyroid	Lupus
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐	☐	☐

Chemical Sensitivity	Atopic Dermatitis
☐	☐
☐	☐
☐	☐
☐	☐

Cause of death:
Mother: ____________
Father: ____________
Brother: ____________
Sister: ____________

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Name: ____ **Date:** ______________

Please complete the following review of your health picture.
While these conditions may not seem directly related to the reason you are here,
this information will help the doctor get a better idea of your overall health past and present.
Please indicate any conditions that you have presently or have had in the past with the onset year.

Childhood Illnesses:
___ ADD/ADHD ___ Allergies ___Anemia ___ Asthma ___ Bedwetting ___ Cerebral Palsy ___ Diabetes
___ Ear Infection ___ Fetal Drug Exposure ___ Food Allergies: ______________________________
___ Headaches ___ Measles ___ Mumps ___ Psoriasis ___ Scoliosis ___ Seizures ___ Spina Bifida

Adult Illnesses:
___ Alzheimer's ___ Anemia ___Arthritis ___ Asthma ___ Cancer ___ Crohn's/colitis ___ CVA (stroke)
___ Cystic kidney disease ___ Depression ___ Diabetes (insulin dep./non insulin dep.) ___ Eczema
___ Emphysema ___ Eye Problems ___ Fibromyalgia ___ Heart Disease ___ Hepatitis ___ HIV
___ Hypertension ___ Liver Disease ___ Lung Disease ___ Lupus ___ Multiple Sclerosis ___ Parkinson's
___ Pneumonia ___ Psoriasis ___ Psychiatric concerns ___ Scoliosis ___ Seizures ___ Shingles
___ STD ___ Suicide attempt(s) ___Thyroid problems ___ Vertigo ___ Other: ________________

Injuries: (Please list date and explanation)
___ Back injury ___ Broken bones ___ Head injury ___ Loss of consciousness ___ Industrial accident
___Joint injury ___ Auto Accident (Date(s) ______________________ ___ Laceration
___ Other: ____
Explanation ____
____

Surgeries: (Please list any surgeries you have had with the date)
___ Tonsillectomy ___ Appendectomy ___ Gall Bladder ___ Back surgery ___ Tubes in ears ___ Female Organs
___ Rectal Surgery ___ Other: ____
____

Medications & Vitamins: (Please list your current medications and vitamins and the dosages)
____
____
Do you have any known adverse drug reactions? ______________________________

Females ONLY:
Pregnancy History:
___ # of complicated pregnancies ___ # of uncomplicated pregnancies ___ # of C-Sections
___ # of vaginal deliveries ___ # of miscarriages ___ # of terminated pregnancies
Menstrual History:
___ regular ___ irregular ___ age of first menses ___ age when menopause began

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Name:________________________________ **Date:** ____________

Review of Systems

Often seemingly unrelated complaints that you might not think to mention indicate a pattern in the bigger picture of holistic health. Please check accordingly:

1= Previously experienced 2= Occasionally experienced 3= Presently experienced 4= Presently severe

General Symptoms	1	2	3	4
Headache	☐	☐	☐	☐
Fever	☐	☐	☐	☐
Chills	☐	☐	☐	☐
Night Sweats	☐	☐	☐	☐
Fainting	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Convulsions	☐	☐	☐	☐
Loss of Sleep	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐
Loss of Weight	☐	☐	☐	☐
Numbness/pain of arms/legs/hands	☐	☐	☐	☐
Allergy_____	☐	☐	☐	☐
Wheezing	☐	☐	☐	☐

Gastro-intestinal	1	2	3	4
Poor Appetite	☐	☐	☐	☐
Poor Digestion	☐	☐	☐	☐
Belching or gas	☐	☐	☐	☐
Nausea/Vomiting	☐	☐	☐	☐
Vomiting blood	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Colon Trouble	☐	☐	☐	☐
Hemorrhoids	☐	☐	☐	☐
Liver Trouble	☐	☐	☐	☐
Jaundice	☐	☐	☐	☐
Gallbladder	☐	☐	☐	☐
Abnormal Stool	☐	☐	☐	☐
Gastritis/Ulcer	☐	☐	☐	☐

Eye/Ear/Nose/Throat	1	2	3	4
Poor Vision	☐	☐	☐	☐
Crossed Eyes	☐	☐	☐	☐
Pain in Eyes	☐	☐	☐	☐
Deafness R/L	☐	☐	☐	☐
Earache	☐	☐	☐	☐
Ear Noises (Tinnitus)	☐	☐	☐	☐
Nose Bleeds	☐	☐	☐	☐
Sore Throat	☐	☐	☐	☐
Horseness	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Frequent Colds	☐	☐	☐	☐
Tonsilitis	☐	☐	☐	☐
Sinus Trouble	☐	☐	☐	☐

Muscles & Joints	1	2	3	4
Weakness	☐	☐	☐	☐
Twitching	☐	☐	☐	☐
Stiff Neck	☐	☐	☐	☐
Sore Throats	☐	☐	☐	☐
Backache	☐	☐	☐	☐
Swollen Joints	☐	☐	☐	☐
Tremors	☐	☐	☐	☐
Foot Trouble	☐	☐	☐	☐
Hernia	☐	☐	☐	☐
Spinal Curvature	☐	☐	☐	☐
Pain betw. Shoulders	☐	☐	☐	☐

Skin or Allergies	1	2	3	4
Skin Eruptions	☐	☐	☐	☐
Itching	☐	☐	☐	☐
Bruising easily	☐	☐	☐	☐
Dryness	☐	☐	☐	☐
Boils	☐	☐	☐	☐
Sensitive Skin	☐	☐	☐	☐
Hives or Allergies	☐	☐	☐	☐
Eczema	☐	☐	☐	☐

Respiratory	1	2	3	4
Chronic Cough	☐	☐	☐	☐
Spitting blood	☐	☐	☐	☐
Spitting Phlegm	☐	☐	☐	☐
Chest Pain	☐	☐	☐	☐
Difficulty Breathing	☐	☐	☐	☐

Cardiovascular	1	2	3	4
Rapid Heart	☐	☐	☐	☐
Slow Heart	☐	☐	☐	☐
High Blood Pres.	☐	☐	☐	☐
Low Blood Pressure	☐	☐	☐	☐
Pain over Heart	☐	☐	☐	☐
Prev. heart trouble	☐	☐	☐	☐
Swelling Ankles	☐	☐	☐	☐
Poor Circulation	☐	☐	☐	☐
Varicose Veins	☐	☐	☐	☐
Stroke	☐	☐	☐	☐

Genito-Urinary	1	2	3	4
Frequ. Urination	☐	☐	☐	☐
Painful Urination	☐	☐	☐	☐
Blood in urine	☐	☐	☐	☐
Kidney Infection	☐	☐	☐	☐
Bed Wetting	☐	☐	☐	☐
Prostate Trouble	☐	☐	☐	☐
Inability to control urine	☐	☐	☐	☐

Female Conditions	1	2	3	4
Painful Periods	☐	☐	☐	☐
Excessive Flow	☐	☐	☐	☐
Irregular Cycle	☐	☐	☐	☐
Hot Flashes	☐	☐	☐	☐
Cramps or Backache	☐	☐	☐	☐
Vaginal Discharge	☐	☐	☐	☐
Vaginal Yeast Infection	☐	☐	☐	☐
Vaginal Discharge	☐	☐	☐	☐

4144 Haywood Road, Suite D
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Fax 828-892-8897

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Name:______________________________ **Date:** ______________

Tests and Immunizations (Please provide approximate dates)

Blood Profile ______________	HIV Test ______________
Breast Exam ______________	PAP Smear ______________
Breast Mammography ______________	Pneumonia Vaccine ______________
CBC ______________	Pulmonary Function ______________
Chest X-Ray ______________	Rectal Exam ______________
Cholesterol, Triglycerides ______________	Sigmoidoscopy ______________
Complete Physical ______________	Sodium & Potassium ______________
EKG ______________	Stool, Occult Blood ______________
Enlarged Heart ______________	Tetanus (DPT) ______________
Flu Shot ______________	Treadmill Test ______________
Genitalia Exam (Male) ______________	Urinalysis ______________

Social History

- Do you use tobacco products? Y/N What type? ______________ How much per day? __________
- Do you drink alcohol? Y/N What kind? ______________ How much per week? __________
- Do you drink coffee? Y/N How many cups per day? ________
- Do you drink sodas? Y/N How many cups per week? ________
- Any other types of stimulants? Y/N What kind? ______________ How much per week? __________
- Do you exercise? □ None □ Occasional □ Weekly □ Daily Details: ______________
- How well do you sleep and in what position? ______________________________
- What level of lifestyle stress would you estimate you have? ______________________
- Please specify the % of each of the following in your daily diet:

  ___ Whole grains ___ Fresh Vegetables ___ Nuts & Seeds ___ Fresh Fruits ___ Dairy
  ___ White meat ___ Red meat ___ Canned Food ___ Frozen Food ___ Fast Food
  ___ Other (please specify) ______________________________

The above information is complete and accurate to the best of my knowledge.

Patient's signature ______________________________ Date ______________

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Welcome to the Office

Date ___________ First Name ____________________ M.I. ____ Last Name ____________________

Address ______________________________ City/State/ZIP ____________________

Home/Cell Phone# ______________ Work Phone ______________ Spouse's phone ______________

Email ____________________________ Driver's License # ____________________

Social Security # _____-____-_____ Birth Date ____________ Age ______ Sex ____

Marital Status S M D W Spouse/Partner's Name ____________________________

Children(s) Names and ages: ____

Employer ____________________________ Occupation ____________________

Spouse's Employer ______________________ Spouse's Occupation ____________________

Emergency Contact & phone # ______________________________ Relationship ____________

How were you referred to our office? ____________________

Have you ever had Chiropractic care before? ____________ If yes, when and where? ____________________

Please check reasons for consulting our office:

_____ I am interested in wellness and natural health care
_____ I am concerned about my health and looking for answers
_____ I am in pain and need help
_____ I have a specific condition that concerns me
_____ I am here for a free 15 minute initial consultation and am considering becoming a patient. I understand there is a charge for consultations after the initial 15 minutes.
_____ Other

INSURANCE INFORMATION

- Is this injury/illness work-related? ________ Have you reported it to your employer? ________
- Do you have any type of Health Insurance? Y/N Name of Insurance Company ____________________
  Guarantor's Name ______________________________ Guarantor's Date of Birth ______________

**** Please allow the front desk assistant to make a copy of your insurance card and driver's license for verification ****

FINANCIAL POLICY

Our policy requires payment in full for the first visit for all services rendered at the time of service to allow time to verify insurance coverage. There is a 10% time of service discount. As a courtesy we will file your health insurance but you understand and agree that regardless of third party liability (insurance of any kind) you are ultimately financially responsible for all charges incurred on your account. You further understand and agree that if your account is not paid within 90 days from the date of service (and other payment arrangements have not been made) the assistance of a collection agency will be enlisted and you will be responsible for any expenses incurred in collecting your account.
No call/no show appointments will be subjected to a $30 fee that will not be billed to the insurance. All return checks are subject to a $30 processing fee.

Method of payment for first visit: Cash _____ Check _____ Credit/Debit _____

By my signature I agree that all information given is complete and accurate to the best of my knowledge. I understand that all information given is completely confidential.

Patient Signature ______________________________ Date ______________

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CONSENT FOR TREATMENT

It is understood that treatment for issues that I present with will be goal directed to achieve optimum health and wellness by the use of chiropractic.
I hereby authorize the doctor to examine, assess and treat my condition as he/she deems appropriate. I give my authority for adjustments, modalities, physical therapies or other procedures to be performed. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

PRIVACY PRACTICES – PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (3 pages) for Mills River Family Chiropractic and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.
I understand that this office will properly maintain my records and will use all due means to protect my privacy as outlined in this privacy practices statement.

Signature ______________________________ Printed Name ______________________________Date______________

Your rights as a patient:

-To be treated with respect and consideration without regard to race, creed, national origin, disability, gender or age.
-To obtain complete and current information concerning all aspects of your care.
-To be seen by the doctor of choice.
-To know the name and professional status of all people who provide your care.
-To refuse care and to be informed of the clinical consequences of this action.
-To expect that communications and records are treated confidentially according to current regulations and/or as required by law.
-To understand why tests and procedures are required.
-To understand and receive an explanation of your bill, regardless of source of payment, and options for available payment plans.
-To be advised of any potential involvement in research projects. The patient has the right to refuse to participate in such projects.
-To expect reasonable continuity of care.
-To receive information to make informed consent prior to the start of any procedure and/or provision of patient care.
-To review your personal healthcare record and to receive an explanation of information contained therein within a reasonable timeframe, in accordance with office policy.
-To request an amendment of your personal healthcare record.
-To be free from all forms of abuse or harassment.
-To receive care in a safe and smoke-free environment.
-To receive information about how to submit a complaint or concern, upon request, from Mills River Family Chiropractic.
-To submit a complaint or concern, verbally or in writing, without compromise to your care or access to care.

Your responsibilities as a patient:

-To arrive on time for appointments and to phone Mills River Family Chiropractic if you must cancel or arrive late.
-To provide Mills River Family Chiropractic with a complete and accurate clinical history.
-To ask questions if any aspect of your care is not clear.
-To follow directions concerning clinical management and to express any concerns about your ability to follow such directions throughout the course of care.
-To treat all those involved in Mills River Family Chiropractic community with respect and consideration.
-To take financial responsibility for services provided by Mills River Family Chiropractic.
-To report changes in health status/condition to the clinician providing care.
-To recognize the effect of lifestyle on personal health.
-To be respectful of the property of Mills River Family Chiropractic.