Family First Chiropractic Clinic
Dr. Nichole Gevock DC
119 W 2nd St. Ottumwa, IA 52501
ottumwafamilychiro.com
Ph: 641-954-8598
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Child's Name _____

Mother's Name_____ Phone_____ Email_____

Father's Name_____ Phone_____ Email_____

Address_____City_____State_____Zipcode_____

Parents Employer_____

Insurance Carrier (BCBS, UHC, Iowa Total Care, Amerigroup)_____

Insurance ID Insurance_____ Group Number_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers 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 suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____
_____
_____

Guardian's Signature Authorizing Care:_____
Date:_____

Child's Name _____Child's Date of Birth ____/____/____ Gender: M F

Birth Weight _____ Birth Length_____ Current Weight _____Current length_____

Number and age of Siblings _____

Referred by (Pediatrician, Family/Friend, Google, Facebook, Screening Event, Other)_____

Pediatrician/Family Doctor _____

Last Visit to Pediatrician_____

Purpose of Last Visit _____

Previous Chiropractor_____

Last Chiropractor Visit and Purpose of visit _____

Has your child ever been treated on an emergency basis? If yes, please explain:
_____

Chief Concern/Reason for today's visit _____

_____

Please Circle:
Carrying Presentation: vertex, transverse, breech, face/brow
Type of birth: vaginal, cesarean, induced labor, forceps, suction/vacuum
Location of birth: home, hospital, birth center

Duration of gestation (weeks)_____

Any problems during pregnancy? _____
_____

Any problems during labor/delivery? _____
_____

APGAR Score _____

Was there jaundice, cyanosis (blue), congenital anomalies/defects? _____
_____

During pregnancy did mom (please check all that apply)

- receive chiropractic care
- exercise
- have a nutritious diet
- become ill
- experience physical trauma (falls, MVA)
- take drugs, smoke, or drink alcohol
- endure stress

- take supplements
- receive ultrasounds
- receive an epidural
- receive invasive procedures
- vaccine
- take tums
- take Tylenol
- have back pain, rib pain

Was your child breast fed? If yes, for how long? _____

At what age was formula introduced? _____

At what age was dairy introduced? _____

At what age was solid food introduced? _____

Did your child receive vaccinations? If yes which vaccinations? How did they react to the vaccination?
_____
_____

Has your child had antibiotics? If yes, how many, and why? _____
_____

Are there any pets in your home? _____

Are there any smokers in your home? _____

Have you had any difficulty with lactation, bonding, behavior problems, any difficulty sleeping?
_____

How many hours does your child sleep at night? Quality of sleep? _____

Does your child go to daycare? _____what type (In-home, facility, YMCA, IHCC)

What is the average numbers of hours in front of a screen per week?_____

Any evidence of trauma at birth? (please check all that apply)

- bruising
- fast/short birth
- cord around neck
- nerve damage
- odd shaped head
- respiratory problems
- torticollis/wry neck
- stuck in birth canal
- depression

Any falls or accidents during pregnancy? If yes, explain _____
_____
Any hospitalizations during pregnancy? If yes, explain _____
_____

Does your child play a sport? If yes, please list _____

Does your child carry a backpack? If yes, how much does it weigh? _____

Approximately how many hours are spent at play per week? _____

At what age did your child:
hold their head up _____
stand _____
sit unassisted _____
begin to walk_____
begin to crawl _____
vocalize _____

Please check if your child suffered from any of the following

- Headaches
- Dizziness
- Fainting
- Seizures
- Heart Problems
- Earaches
- Sinus problems
- Asthma
- Colds/Flu
- Back Pain
- Colic
- Orthopedic problems
- Neck Problems
- Arm problems
- Leg problems
- Joint problems
- Poor posture
- Scoliosis
- Walking trouble
- Digestive disorder
- Poor appetite
- Stomach aches
- Reflux
- Constipation/Diarrhea
- Diabetes
- Hypertension
- Anemia
- Bed wetting
- ADD/ADHD
- Autism
- Ruptures/Hernias
- Muscle pain
- Growing pains
- Allergies

Has your child ever suffered from falls or spinal traumas? baby walker, highchair, changing table, bed, couch, swing, slide, monkey bars, skateboard, skates, bicycle, stairs, other, please specify _____
_____

Is there any family history of neck pain, back pain, headaches, migraines, scoliosis, disc problems, nerve pain, arthritis, cancer, diabetes, heart problems? (circle all that apply)

I certify the information provided is accurate to the best of my knowledge:
Name of Patient _____
Signature of Patient/Legal Guardian _____
Date _____