Kitsap Chiropractic
Dr. Jennifer H. Sansen
200 Bethel Road
Port Orchard, WA 98366

PEDIATRIC HISTORY FORM

Patient Name: ____

Address: ________________________ City: ____________________ State: ______ Zip: _________

Date of Birth: ____________________ Age: ________ Sex: ________ Weight: _______ Height: _______

Referred By: ____

Name of Parents/Guardians: ____

Best place to contact parent/guardian by phone: ____

PURPOSE FOR CONTACTING US ? ____

Other Doctors Seen for this Condition: Yes or No, Doctors' Names and Prior Treatments:

____

____

Other Health Problems ? ____

Check any of the following conditions your child has suffered from during the past six months:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma/Allergies	Digestive Problems	ADHD	Recurring Fevers	Growing/Back Pains
Colic	Bed Wetting	Car Accident	Temper Tantrums	Other ________

Family History: ____

Previous Chiropractic Care: ☐ Yes ☐ No

Name of Pediatrician: ____

Date of Last Visit: ______/_______/_______ Reason: ____

Current Medications: ____

Vaccination History: ☐ All Current ☐ Not Vaccinated

Vaccination Reactions: ____

PRENATAL HISTORY:

Name of Obstetrician/Midwife: ____

Complications During Pregnancy ? ______ N ______ Y, List: ______________________________

Ultrasounds During Pregnancy ? ______ N ______ Y, Number: ___________

Medications During Pregnancy ? ______ N ______ Y, List: ______________________________

Cigarette/Alcohol Use During Pregnancy ? ______ N ______ Y

Location of Birth: _______ Hospital _______ Birthing Center _______ Home

Birth Intervention: _______ Forceps _______ Vacuum Extraction _______ Caesarian Section, Emergency or planned.

Complication During Delivery ? _______ N _______ Y, List: ______________________________

Genetic Disorders or Disabilities? ______ N _______ Y, List: ______________________________

Birth Weight: _______ Birth Length: _______ APGAR Scores: _______, _______

FEEDING HISTORY:

Breast Fed: _______ N _______ Y, How Long: ____________

Formula Fed: _____ N _______ Y, How Long: ____________ Type: ______________________________

Introduced to Solids at: _______ Months, Cows' Milk at: _______ Months

Food/Juice Allergies or Intolerances: _______ N _______ Y, List: _________________________________

____

DEVELOPEMENTAL HISTORY:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_______ Respond to Sound
_______ Respond to Visual Stimuli
_______ Hold Up Head
_______ Sit Up
_______ Cross Crawl
_______ Stand Alone
_______ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.).
Was this the case with your child? _______ N _______ Y

Is/has your child been involved in any high impact type sports (i.e., Soccer, Football, Gymnastics, Baseball, cheerleading, Martial Arts, etc.) ? _______ N _______ Y, List: ___________________________________

____

Has Your Child Ever Been Involved in a Car Accident? _______ N _______ Y, List: __________________

Has Your Child Been Seen on an Emergency Basis? _______ N _______ Y, List: _____________________

Other Traumas Not Described Above? _______ N _______ Y, List: _______________________________

Prior Surgery: _______ N _______ Y, List: ____

Menarche: _______ N _______ Y, Age: _______

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: ____ Date: ______________________________