Dr.Terrie G. Huls 156 Kruger Street Ste. B Wheeling, WV 26003

## Pediatric Patient



## **Confidential Patient Information**

Child's First Name:		Child's Last Name:		Date:
DOB: Age:	Sex: M	F Height:	Weight:	School Status:
Parent(s)/ Guardian(s): Primary Phone:				
Address:				
Emergency Contact: Relationship to child: Phone:				
How did you hear about us?	Referred by:	Soci	al Media We	ebsite/Google Phonebook
Your Reason For Seeking Care (mark all that apply)				
General Wellness Di	scovering the CAUSE	e of my child's health ch	allenge(s) CLe	arning natural healing strategies
Specific health concern(s) Please explain:				
What do you want to see as a result of chiropractic care for your child? (ex: I want my child to have less ear infections.)				
Has your child received chiropractic care before? Yes No Good experience? Yes No Approximately how long was this child under care? # Days Weeks Months Years				
Reason for discontinuing previous care or seeking care with us:				
Have you consulted other health care providers for your concerns? Yes No If yes, who?				
What was the outcome or prognosis?				
What else should Dr. Huls know?				
Health History				
Hobbies/Sports:				
Broken Bones/Surgeries/Accidents/Hospitalized:				
Medications:				
Prenatal and Newborr	. Hictory			
Location of birth?		oor and delivery?	Birth weigl	
Did any of the following happen during labor or delivery? C-section delivery Doctor pulled/pushed/twisted baby  Anesthesia/Epidural Labor was induced Forceps/Vacuum extraction Premature delivery Stalled labor				
Describe any of the above plus any additional complications:				
Did this child spend any time in the NICU?				
Ultrasound(s) used during pregnancy?   Yes No # of times:				
Did mother breastfeed the baby?  Yes No If yes, how long? Rate mother's diet: Excellent				
Did this child receive formula? Yes No If yes, how long?				
At what age did you introduce	: Solid food:	Cow's milk:	Soy milk:	Fruit juice: