



Achieve Health

Chiropractic / Naturopathic / Massage Therapy/ Acupuncture
Dr. Deirdre O'Neill

Today's Date _____

Pediatric/Adolescent Case History

Patient's Name _____ Age _____ Date of Birth _____ Sex _____

Address _____

Mother's Name _____ Father's Name _____

Phone (Home) _____ (Work) _____ mother / father / other

Referred By _____

Person to be Notified in Case of Emergency:

Name _____ Relationship _____ Phone _____

Address _____

Please List Most Important Health Concerns/Problems

Please List any Medications or Supplements Taken

Childhood Illnesses

- Chicken Pox
- Measles
- Mumps
- Rubella
- Whooping Cough

- Scarlet Fever
- Rheumatic Fever
- Strep Throat
- Pneumonia
- Asthma

- Mononucleosis
- Ear Infections
- Tonsillitis
- Croup
- Other _____

Name: _____ DOB: _____

Immunizations (List types, dates given, and any adverse reactions)

Hospitalizations/Surgeries/Accidents/Serious Injuries

(Describe each incident and give date)

Family History: Identify all family members who have or have had any of the following

_____ Alcoholism	_____ Diabetes	_____ High Blood Pressure
_____ Allergies	_____ Eczema	_____ Mental Illness
_____ Anemia	_____ Epilepsy	_____ Obesity
_____ Arthritis	_____ Heart Disease	_____ Stroke
_____ Asthma	_____ Hearing Loss	_____ Thyroid Disorder
_____ Birth Defects	_____ Hypoglycemia	_____ Other (describe)
_____ Cancer		

Infant's/Child's/Adolescent's Health History Please write **C** for **current** or **P** for **past**

___ Acne	___ Diarrhea	___ Hyperactivity
___ Allergies	___ Dizzy spells	___ Insomnia
___ Asthma	___ Earaches	___ Jaundice
___ Bed Wetting	___ Eczema	___ Learning Disorder
___ Birth defects	___ Epilepsy/Seizures	___ Moodiness
___ Colic	___ Fatigue	___ Stuffy Nose
___ Constipation	___ Frequent Infections	___ Thrush
___ Cough/Wheeze	___ Headaches	___ Vomiting Spells
___ Cradle cap	___ Heart Murmur	
___ Depression	___ High fever	

Other _____

What is Your Infant's/Child's/Adolescent's Disposition?
