

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Atlas Chiropractic**  
**4131 W Thunderbird Rd**  
**Phoenix, Az 85053**  
**602-938-8868**  
**Children's Case History**

PT ID #: \_\_\_\_\_

(Please Print)

Child's Name: \_\_\_\_\_

First

Last

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Current WT & LGTH: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

First

Last

Father's Name: \_\_\_\_\_

First

Last

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_-

Work: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Email: \_\_\_\_\_

Place of Birth: (Check one of the following)  Home  Hospital  Birthing Center  Other

Problems with Delivery or Labor: \_\_\_\_\_

Was Child Cyanotic (Blue Baby): \_\_\_\_\_ Jaundice (Yellowish) \_\_\_\_\_

Describe Birthmarks, If Any: \_\_\_\_\_

Apgar Score, If known: \_\_\_\_\_

Immunizations or Other Toxins: \_\_\_\_\_

Family History: (Check one of the following)  Retardation  Diabetes  Epilepsy  Allergies  Other:

Type of Feeding:  Breast  Bottle  Formula (Brand Name) \_\_\_\_\_

Child's Symptoms and/or Parent's Comments: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian