Lykens Chiropractic
OPTIMUM HEALTH FOR YOUR ENTIRE FAMILY

Appt: Client #

CHILD (6-11 yo) INFORMATION

Child's Name: _____ Date: ____/____/____ Referred by: _____
First MI Last
Address: _____ City/State/Zip: _____
Social Security #_____ Birth Date: ____/____/____ Gender: Male___ Female___

CMS requires providers to report both race and ethnicity:
Race (circle one): American Indian or Alaska Native / Asian / Black or African American / White (caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer
Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Parent/Guardian 1: _____ Phone # (H)_____ (W)_____
Address (if different)_____ Cell #_____
Social Security #_____ Date of Birth _____
Employer_____

Parent/Guardian 2: _____ Phone # (H)_____ (W)_____
Address (if different)_____ Cell #_____
Social Security #_____ Date of Birth _____
Employer_____

Pediatrician_____ Date of last medical exam _____
Other Providers_____
Previous Chiropractor_____ For what reason_____
Frequency of previous chiropractic care_____ Date of last adjustment_____

HEALTH HISTORY

Current diagnosed conditions: _____
Previous diagnosed conditions: _____
List all current prescriptions, over the counter medications and vitamin supplements your child is taking:
_____
Allergies: _____
List all hospitalizations and surgeries and give dates:_____
List **ANY & ALL** lifetime trauma history to head, neck, or back (such as concussion, auto/bike accident, sports/play injury, etc) EVEN IF YOUR CHILD DID NOT HAVE ANY SYMPTOMS OR TREATMENT FOLLOWING THE TRAUMA:
_____
Any trips to the ER? YES / NO If YES Explain: _____
List all sports: _____
List activities of prolonged, awkward postures? (gaming, reading, gymnastics, dance, instruments, etc.):
_____

Lykens Chiropractic
OPTIMUM HEALTH FOR YOUR ENTIRE FAMILY

PRESENT & PAST ISSUES

Explain child's current symptoms or issues: _____
_____
When did it start: _____ How frequent: _____
What treatments have you tried for this: _____
What makes it better: _____
What makes it worse: _____

(Please **X** all that apply)

___Neck pain
___Mid back pain
___Low back pain
___Headaches
___Ear infections
___Sinus problems
___Frequent colds/flu/illness
___Asthma
___Reflux
___Diarrhea/constipation
___Heart problems
___Bed-wetting
___Kidney/bladder problems
___Scoliosis
___Growing pains
___TMJ dysfunction
___Dizziness
___Convulsions/Seizures
___Sleep problems/night terrors
___ADD/ADHD
___Mental/Emotional problems. List: _____
___Autism Spectrum diagnosis. List: _____
___Other:_____

Parent/Guardian Name: _____ Date: _____
Signature of Parent/Guardian_____

To be completed by the Doctor:

EXAM

Upper Crossed / Lower Crossed / Neutral
Head Rotation: None / Lt / Rt
Head Tilt: None / Lt / Rt
High shoulder: Even / Lt / Rt
High pelvis: Even / Lt / Rt
Genu Valgus: None / Lt / Rt
Genu Varus: None / Lt / Rt
Toe Rotation: None / Lt: In / Out Rt: In / Out
Foot: Neutral / Lt: Pronation / Supination Rt: Pronation / Supination
Foot Medial Arch: Normal / Lt: Flat / High Rt: Flat / High