Lykens Chiropractic
OPTIMUM HEALTH FOR YOUR ENTIRE FAMILY

Appt: Client #

PEDIATRIC (0-5 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_____

Obstetrician/Midwife_____ Pediatrician_____
Date of last medical exam _____ Other Providers: _____
Previous Chiropractor_____ For what reason_____
Frequency of previous chiropractic care_____ Date of last adjustment_____

BIRTH HISTORY

Mother's medications during pregnancy: _____
At how many weeks (gestational age) was the child born: _____ wks _____ days
Delivery Method: *(circle)* Vaginal delivery / Emergency C-section / Scheduled C-section
Epidural: YES / NO Were forceps or suction used during delivery: YES / NO *(If YES, circle which one)*
Was labor induced: YES / NO How many hours was labor: _____ How many minutes of pushing: _____
Baby's presentation at time of birth ___head-first ___breech ___other_____
Birth Weight: _____lbs_____oz Length: _____inches Final APGAR Score: _____
Has your child been vaccinated: YES / NO If YES, did you follow an alternate vaccine schedule: YES / NO
Were there any side effects or complications noticed with any of them: YES / NO
If so, please explain_____

HEALTH HISTORY

Was your child breast fed? YES / NO If so, for how long? _____
Allergies: _____
Current diagnosed conditions: _____
Previous diagnosed conditions: _____
List all current prescriptions, over the counter medications and vitamin supplements your child is taking:
_____

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? YES / NO
Explain: _____
Other injuries, traumas or accidents & give dates: _____
Any trips to the ER? YES / NO If YES Explain: _____
List all hospitalizations and surgeries. Give dates: _____

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: _____

PAST & PRESENT CONDITIONS

(Please **X** all that apply)

___Latching problems
___Ear infections
___Asthma
___Diarrhea/constipation
___ADHD
___Growing pains
___Torticollis
___Speech difficulties
___Fractured bones Where:_____
___Other:_____

___Tongue / Lip Tie
___Sinus problems
___Heart problems
___Reflux
___Autism
___Convulsions/Seizures
___Scoliosis
___Skin problems

___TMJ problems
___Frequent colds / flus
___Kidney / bladder problems
___Colic
___Sleep problems / night terrors
___Mental/emotional disorders
___Bed-wetting
___Visual problems

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

To be completed by the Doctor:

EXAM

Head Rotation None / Lt / Rt
Head Tilt None / Lt / Rt
High shoulder Even / Lt / Rt
Genu Valgus None / Lt / Rt
Genu Varus None / Lt / Rt
Rooting Reflex Lt / Rt
Palmar Grasp Reflex Lt / Rt
Plantar Grasp Reflex Lt / Rt
Tonic Neck/Fencer Reflex Lt / Rt
Palmer Grasp Lt / Rt
Moro Reflex
Babinski Lt / Rt
Galant Reflex Lt / Rt
Ortoloni Sign Lt / Rt
Barlow Sign Lt / Rt

(2 to 6 months) Asymmetrical Tonic Reflex
(<3-9 months) Galant Reflex Lt/Rt
(<4 months) Rooting Reflex Lt/Rt
(<4 months) Tonic Neck/Fencer Reflex Lt/Rt
(<4-6 months) Palmar Grasp Reflex Lt/Rt
(4 to 24 months) Neck Righting Reflex
(<6 months) Ortoloni Sign Lt/Rt
(<6 months)Barlow Sign Lt/Rt
(<6 months) Moro Reflex
(6 to 12 months) Symmetrical Tonic Reflex
(<9-12 months) Plantar Grasp Reflex Lt/Rt
(<12 months) Babinski Lt/Rt
2 yo - jumps with both feet
3-4 yo walks on heels
4-5 walks on tiptoes