

Dr. Melissa O'Loughlin
23 Coach St. Canandaigua, NY 14424

PEDIATRIC REGISTRATION &
HISTORY FORM

Child's Name: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

1st Parent's Name: _____ Work Phone: _____

2nd Parent's Name: _____ Work Phone: _____

Would you like our free monthly Wellness Newsletter by email? Yes No email: _____

Birth date: _____ Age: _____ Sex M F No. of siblings: _____

Birth Weight: _____ Current Weight: _____

Birth Length: _____ Current Length: _____

Type of birth(check all that apply): Normal Vaginal Forceps Vacuum
Breech C-section Home
Birth Center (name) _____
Hospital (name) _____

Problems during pregnancy: _____

Problems during labor/delivery: _____

APGAR Scores: _____ At birth, was there a presence of: Jaundice (yellow)
cyanosis (blue)

Congenital anomalies/defects: _____

Infant Feeding – Please list at what age the child received each method.

Breast _____ Bottle _____ Formula _____

No. hours sleep per night: _____ Quality of sleep: Good Fair Poor Explain: _____

Obstetrician/Midwife: _____
Name Location

Pediatrician: _____
Name Location Phone

Date of last visit to MD: _____ Purpose: _____

Immunization History: _____

Has your child ever been treated on an emergency basis? Y N Explain _____

Purpose of today's appointment: _____

Whom may we thank for referring you to our office? _____

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PERSONAL HEALTH HISTORY - Has this child ever suffered from:

Dizziness	Backaches	Heart trouble	Diabetes
Tuberculosis	Colds/Flu	High blood pressure	Arthritis
Headaches	Asthma	Neuritis	Colic
Digestive trouble	Sinus trouble	Constipation	Bed-wetting
Anemia	Rheumatic Fever	Orthopedic problems	Diarrhea
Poor appetite	Hyperactivity	Sugar concentration	Behavioral problem
Convulsions	Paralysis	Muscle jerking	Fainting
Walking problems	Broken bones	Ruptures/Hernia	Neck problems
Arm problems	Leg problems	"Growing Pains"	Joint problems
Blood disorders	Stomach aches	Chronic Ear Infections	Cancer

Surgeries: _____

Medications (name & purpose): _____

Allergies _____

FAMILY HEALTH HISTORY

Please place a check mark if someone in the child's immediate family has had the following. Please write how they are related to the child.

Back Problems _____	Headaches _____
High blood pressure _____	Ulcer/Digestive Problem _____
Thyroid Disorder _____	Heart Disease _____
Stroke _____	Arthritis _____
Diabetes _____	Cancer _____
Osteoporosis _____	Mental Illness _____

WELLNESS PROFILE

Chiropractic care affects more than our just muscles and bones. Please share with us what health goals you hope to find for this child. Check as many boxes as you wish.

more energy	better sleep	freedom from pain
better concentration	easier breathing	more balanced posture
try quality vitamins	improve nutrition	improved coordination
reduce medications	improve overall health	better sports performance
enhanced emotional well-being	greater resistance to disease	other _____

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PERMISSION TO EXAMINE AND TREAT A MINOR

I, _____, give my consent to Dr. Melissa O'Loughlin
parent/guardian
to examine and treat my child, _____.
patient

I understand that care given at this office is not intended to treat any disorders or infections such as ear infections, ADD/ADHD, autism, and related spectrum disorders or any other neurological or developmental condition; nor will myself nor my insurance company be billed as such.

Treatment will be that of evaluating and providing chiropractic care for the presence of the vertebral subluxation of the spine, and, if necessary, recommending various appropriate nutritional changes and exercises to promote proper neurological function and/or development. I understand that I may ask Dr. O'Loughlin questions regarding the above statements at any time.

Print Name: _____

Signature of Legal Representative: _____
(Parent or Guardian if a minor)

Relationship to Patient: _____

Date Signed: _____

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PEDIATRIC WELLNESS
PROFILE

We are interested in other aspects of health -- mind, body, and spirit. There may be seemingly insignificant events that are contributing to today's picture of your child. Please to the best of your ability.

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? Yes / No

If no, explain: _____

At what age did the child: Respond to sound _____ Follow an object _____

Hold up head _____ Vocalize _____ Sit Alone _____ Teethe _____

Crawl _____ Walk _____

Chemical Stressors

Age when child was:

introduced to cow's milk? _____

Began solid foods? _____ Type: _____

Introduced to juice? _____

Juice/food intolerances? Y N Explain: _____

During pregnancy, did the mother

smoke? Y N Unknown

drink alcohol? Y N Unknown

take supplements? Y N Unknown

Any pets at home? Y N Type: _____

Any smokers at home? Y N

Psychosocial Stressors

Any difficulties with lacion? Y N _____

Any problems with bonding? Y N _____

Any behavioral problems? Y N If yes, state onset, any triggers, etc _____

Average number of hours of television / week: _____

Approximate hours spent at play per day _____

Does your child play before school? _____

Traumatic Stressors

Any trauma during pregnancy? (falls, accidents) Y N _____

Any evidence of birth trauma (please circle): bruises, odd shaped head, stuck in birth canal,
fast or excessively long birth, respiratory depression, cord around neck, other _____

Any falls from crib, bed, changing tables? Y N _____

Sports played and age began _____

Weight of school backpack: _____

Very often, parents know their children better than any doctor. To you, does your child seem
"normal" for their age? Y N If no, please explain in the space below:

Thank you for completing these forms.

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PRIVACY ACT,
INFORMED CONSENT, & OFFICE POLICIES

NOTICE OF PATIENT PRIVACY RIGHTS

By signing below, I acknowledge that I have received a copy of the "Notice of Privacy Practices" and a copy will be available for me at the reception desk upon my request. The Health Insurance Portability and Accountability Act ensures a patient's right to privacy regarding Personal Health Information and it is this office's policy to maintain confidentiality to the highest degree.

Patient/Legal Guardian's Initials: _____

INFORMED CONSENT

Any procedure intended to help may also do harm. While chiropractic examination and therapeutic procedures are usually considered remarkably safe and effective, please understand that occasionally there may be adverse reactions. Although the chances of experiencing any of these complications are extremely small, it is the practice of this chiropractic office to fully inform and educate all of our patients.

By signing below, I understand that these complications include, but are not limited to, muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor to be able to anticipate or explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of my treatments which they feel at the time, based upon the facts then known, is in my best interests.

I understand that there is no guarantee or warranty for a specific cure or result. I understand that at any time, I can request further explanation regarding risks and benefits of care in this office, alternative courses of care, and the consequences of not having the proposed treatment.

Patient/Legal Guardian's Initials: _____

OFFICE POLICIES

I agree to take full financial responsibility for my care in the event that the assumed coverage (Worker's Compensation, No Fault Insurance, health insurance coverage, etc) is denied.

I further understand that the office charges a \$20 fee for returned checks. The office reserves the right to charge for appointments canceled without 24 hours notice and for not attending scheduled appointments.

I also understand that fee-for-service is required at the time of service or the office reserves the right to charge a \$5 fee.

Patient/Legal Guardian's Initials: _____

I HAVE READ THIS FORM IN ITS ENTIRETY AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENTS.

Patient/Legal Guardian Signature: _____

Print Name: _____ **Date:** _____

Doctor's Signature: _____
Date: _____

Thomas C. Wright, DC
Marcella M. Burkard, DC
Melissa S. O'Loughlin, DC
23 Coach St.
Canandaigua, NY 14424
(585) 394-2030

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under that Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

By signing below, I certify that I have received the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office, at any time, at the address above, to obtain a current copy.

Print Name: _____

Signature: _____

Signature of Legal Representative: _____
(Parent or Guardian if a minor)

Relationship to Patient: _____

Date Signed: _____