Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051 | Fax (781)933-5054
winchesterchirocenter@gmail.com
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Lactating Parent Intake

Today's Date: _____

Mother's Name		Baby's Name		Sex	
Home Address City/St/Zip					
Cell Phone		Email			
Mother's Date of Birth		Mother's Current Age		Baby's Date of Birth	
Main Reason for Appointment Today					

CHECK ANY BOXES YOU HAVE BEEN EXPERIENCING OVER THE PAST MONTH:			
☐	DIFFICULTY LATCHING	☐	BABY SLEEPY AT BREAST
☐	PAIN WITH LATCHING	☐	BABY REFUSES TO NURSE
☐	SORE, IRRITATED NIPPLES	☐	BABY ALWAYS SEEMS HUNGRY
☐	CRACKED OR BLEEDING NIPPLES	☐	BABY PREFERS 1 BREAST MORE THAN OTHER
☐	BREAST PAIN	☐	SLOW WEIGHT GAIN OF BABY
☐	CLOGGED DUCTS	☐	BABY SLIPS OFF BREAST EASILY/SHALLOW LATCH
☐	MASTITIS	☐	BABY BITES OR CHOMPS AT BREAST OR BOTTLE
☐	ENGORGEMENT	☐	BABY'S TONGUE CLICKS OR A WHISTELING SOUND IS HEARD
☐	OVER SUPPLY	☐	MOM HAS HAD FEVER OR CHILLS
☐	LOW MILK SUPPLY	☐	BABY NOT TRANSFERRING MILK WELL
☐	MILK NEVER CAME IN	☐	USE A NIPPLE SHIELD
☐	MOM HAS HAD FEVER OR CHILLS	☐	USE A BREAST PUMP
☐	OTHER PROBLEMS-DESCRIBE:	☐	EXCLUSIVELY PUMPING NOW

SOCIAL HISTORY
☐ MARRIED ☐ SINGLE ☐ IN A RELATIONSHIP ☐ DIVORCED
OCCUPATION:
☐ SMOKER ☐ NON SMOKER ☐ EX SMOKER ☐ NEVER SMOKED
☐ ALCOHOL USE ☐ CAFFEINE USE ☐ STREET DRUG USE
LIST MEDICATIONS YOU ARE TAKING NOW:
DESCRIBE YOUR MENTAL HEALTH NOW:

PREGNANCY INFO
OB/MIDWIFE NAME:
FERTILITY TREATMENT?
NUMBER PREVIOUS BIRTHS:
PREGNANCY CHALLENGES?
MEDS TAKEN DURING PREG?
TREATMENTS RECEIVED DURING PREG?
DID BREASTS CHANGE IN SHAPE AND SIZE DURING PREG?
DID YOU TAKE A BREASTFEEDING CLASS?

BIRTH HISTORY FOR THIS BABY:	**BREASTFEEDING INFO:**
NAME OF HOSPITAL:	EVER BREASTFED A BABY BEFORE?
DELIVERED HOW MANY WEEKS INTO PREGNANCY? Ex 38.4	WAS BABY PUT TO BREAST WITHIN THE FIRST HOUR?
BABY BIRTH WEIGHT:	HAVE YOU SEEN A LACTATION PROFESSIONAL SINCE DISCHARGE?
BABY BIRTH LENGTH:	IF SO, WHOM AND DATE LAST VISIT:
ANY STRESSFUL COMPLICATIONS WITH YOU OR BABY?	BIGGEST BREASTFEEDING HURDLE SO FAR:
TYPE OF BIRTH TO CHECK OFF FOR THIS BABY:	PLEASE CHECK ANY ADDITIONAL INTERVENTIONS:
☐ VAGINAL ☐ PLANNED C-SECT ☐ EMERGENCY C-SECT ☐ VBAC	☐ INDUCED ☐ VACUUM ☐ FORCEPS ☐ EPISIOTOMY ☐ EPIDURAL

LACTATING MOTHER'S GENERAL HEALTH HISTORY-CHECK ANY BOXES THAT APPLY TO YOU

GENERAL	EYE, EAR, NOSE, THROAT	GI/GU	CARDIO
☐ Anemia	☐ Blurred vision	☐ Bladder Trouble	☐ Chest Pain
☐ Anorexia/Bulimia	☐ Chronic Cough	☐ Bloating/Gas	☐ Heart Disease
☐ Anxiety	☐ Chronic Sinus issues	☐ Bowel Changes	☐ High Blood Pressure
☐ Arthritis	☐ Double Vision	☐ Colitis/IBS/Crohn's	☐ Irregular Heartbeat
☐ Asthma	☐ Earache/infection	☐ Constipation	☐ Low Blood Pressure
☐ Cancer	☐ Floaters/Haloes	☐ Diarrhea	☐ Poor Circulation
☐ Chemical Dependency	☐ Glaucoma	☐ Excessive Hunger	☐ Raynaud's Disease
☐ Depression	☐ Hay fever/allergies	☐ Excessive Thirst	☐ Swelling of Ankles
☐ Diabetes	☐ Hearing Loss	☐ Frequent Urination	☐ Varicose Veins
☐ Epilepsy/Seizure Disorder	☐ Nosebleeds	☐ Hemorrhoids	☐ Vasospams
☐ Fainting Spells	☐ Postnasal Drip	☐ Hernia	**FEMALE**
☐ Fibromyalgia	☐ Ringing in ears	☐ Incontinence-bladder	☐ Abnormal Periods
☐ Forgetfulness	☐ Shortness of Breath	☐ Incontinence-colon	☐ Breast Lumps/Pain
☐ Hepatitis	☐ Slurred Speech	☐ Indigestion/excess gas	☐ Breast Surgery of any type
☐ High Cholesterol	☐ Swallowing difficulties	☐ Kidney Disease	☐ Cysts, Tumors or Cancer
☐ Multiple Sclerosis	☐ Throat infection	☐ Loss of bowel control	☐ Endometriosis
☐ Night Sweats	☐ Vertigo (dizziness)	☐ Nausea	☐ Extreme Cramps
☐ Osteoporosis/osteopenia	**SKIN**	☐ Painful Urination	☐ Hot Flashes
☐ Paralysis	☐ Bruises Easily	☐ Rectal Bleeding	☐ PCOS
☐ Psychiatric Care	☐ Changes in Moles	☐ Reflux/GERD	☐ Period has returned
☐ Stroke	☐ Eczema/Psoriasis	☐ Stomach Pain	☐ Preeclampsia
☐ Tiredness	☐ Hives/Rash/Itching Skin	☐ Ulcers	☐ Spotting
☐ Thyroid Problems	☐ Sores not healing	☐ UTI	**MUSCULOSKELETAL**
☐ Weight Change-dramatic-unrelated to pregnancy	**OTHER**	☐ Vomiting	☐ Joint Pain-please list:
			☐ Headache or Migraine
			☐ Sciatica
			☐ Other

PLEASE LIST ANY FAMILY HISTORY OF MEDICAL CONDITIONS:

PLEASE LIST ANY SURGERIES YOU HAVE HAD:

I give my consent for Dr. Henrickson to work with me and my baby during this consultation for my breastfeeding problem/concern. This consent is for visits, phone conversations and information sent by secure e-mail and includes appropriate follow-up contact.

I understand that a lactation consultation session may involve:

- touching my breasts and/or nipples for the purposes of assessment and possible massage techniques, ultrasound or laser therapy
- inserting gloved fingers into my baby's mouth to assess suckling motions
- observation of a breastfeeding session and/or pumping
- suggestions to enhance latch or breastfeeding position and techniques
- demonstration of breastfeeding equipment or supplies

I understand it is my responsibility to contact Dr. Henrickson with progress updates, questions or concerns.

- I give my consent for Dr. Henrickson to release any information acquired in the evaluation and/or management of myself and/or my child to our health care providers. I understand she may contact my OBGYN or my child's Pediatrician if she feels it is necessary for a positive outcome.

I understand that the results are not guaranteed. I do not expect the lactation consultant to be able to treat all complications completely. I have read and fully understand the above statements and therefore accept evaluation and guidance on this basis.

PRINT LACTATING PARENT'S NAME: _____

SIGNATURE OF LACTATING PARENT: _____ **DATE:** _____

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PATIENT FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Thank you for choosing Dr. Heidi Henrickson as your lactation provider. Please be assured that the health of our patients is of the utmost importance to us. We thank you for taking the time to review our policies. Your understanding of our Financial Policy is important to our professional relationship with you. Please feel free to ask any questions or share any special concerns that you may have. Your insurance benefits are determined in the contract between you and the insurance company, and it is important that you understand and follow the requirements of your specific insurance policy.

If your child is having difficulties feeding at the breast, we might need to examine both the lactating parent as well as the infant and take a detailed history of the complaints. We might have to observe a feeding for proper diagnosis and to provide you with the best care plan. The infant and lactating parent are each considered a patient therefore we will bill both the infant and lactating parent's insurance plans for the exam and any treatment provided. Each visit may carry their own copay or coinsurance that you will be responsible for.

Co-Payments/Coinsurance/Deductibles

Your specific insurance plan determines the amounts you may be required to pay. Our contract with your plan and applicable laws limit us from discounting or waiving copayments, deductibles, or coinsurance for visits and procedures. Copays are required at the time of every visit, and we accept cash, check or credit card as payment. For your convenience, WCC utilizes a credit card processing system which allows us to keep your credit card on file securely. Please note that no staff members at WCC have access to your credit card number at any time. We will charge your card for amounts due, as indicated by your insurance carrier, unless you advise us otherwise. To find out if your plan will cover, please email drhenrickson@winchesterchirocenter.com. Include a brief description of the problem, the lactating parent's insurance type and subscriber number plus their date of birth as well as the infant's name, date of birth and their insurance type and subscriber number.

No Show / Late Cancel Policy

A $200 surcharge will be applied to your balance if you do not arrive for a lactation appointment as scheduled and do not cancel 24 hours prior to the scheduled visit. We understand there may be unpredictable and unique circumstances that cannot be avoided. Please contact us to explain and discuss any situation which may cause you to cancel or reschedule.

Self-Pay

Payment is expected at the time of visit unless other arrangements have been made with the office manager prior to the visit.

Insurance

We will require a copy of your insurance card for our files. It is your responsibility to inform us of any change in your insurance coverage. We are in network with some plans; however, many companies consider all lactation consultants to be out of network and therefore will not directly pay for care. We can always supply you with a detailed superbill and you can submit to your insurance for possible reimbursement of all or some of the cost of the lactation visit.

Non-Participating Plans

If we are out of network for your insurance and your insurance will be paying you directly, we expect payment at the time of service unless other arrangements have been made prior to the visit. Call member services on the back of your insurance card and ask about the process for submitting for out-of-network reimbursement.

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PATIENT FINANCIAL RESPONSIBILITY

I acknowledge that I have read the above and am responsible for services rendered by Winchester ChiropracticCenter, LLC and its associates. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that copays are due at the time of check in. I authorize WCC to release information to insurance carriers responsible for my care period I authorized my insurance company to pay directly to WCC and Dr. Heidi Henrickson all medical benefits for payment of services rendered by her period I have voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician and other healthcare providers determine to be necessary. During treatment, I understand and acknowledge that no warranty or guarantee has been or will be made as to the result or cure of treatment. I have the legal right to consent to medical treatment because I am the patient.

Name of Lactating mother (please print) _____ Date of Birth_____

Signature _____ Today's Date _____

NO-SHOW POLICY

This policy is to ensure patients have access to care when needed. By not showing up for an appointment you previously scheduled, you are prohibiting another patient from accessing care. You will be billed $200 if you miss a lactation appointment and you have not contacted us to cancel at least 24 hours prior to the scheduled appointment time. To cancel an appointment, please call the office at 781-933-5051. If are not able to speak with a member of the administrative staff, please leave a detailed message with the date and time of your call. You may not cancel an appointment via text or email. Thank you for your cooperation.

Name of Lactating mother (please print) _____ Date of Birth_____

Signature _____ Today's Date _____

NOTICE OF PRIVACY PRACTICES-HIPAA

We are concerned with protecting your privacy, especially in matters that concern personal health information. In accordance with the Privacy Regulations Adopted Under Health Insurance Portability and Accountability Act ("HIPAA") of 1996, we are required to supply you with a copy of our privacy polies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health info and rights as a patient.

I hereby acknowledge that a copy of Winchester Chiropractic Center, LLC (herein after referred to as "WCC") Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about WCC's privacy practices or my rights with regard to my personal health information, I may contact the WCC office manager for further information as set forth in the Notice.

Name of Lactating mother (please print) _____ Date of Birth_____

Signature _____ Today's Date _____