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

PEDIATRIC INTAKE

PERSONAL INFORMATION

Child's Name: _____ Parent's Names: _____

Child's Date of Birth: _____ Age: _____ ☐ Male ☐ Female Height: _____ Weight: _____

Address: _____
Street City State Zip

Parent's cell: _____

Parent's email: _____ Child's pediatrician and location: _____

Who told you about our office: _____ Reason for today's visit: _____

BIRTH PARENT'S PREGNANCY

Any injuries during pregnancy (accidents, falls, etc.) _____

Any treatment received during pregnancy (chiro, PT, massage, acupuncture, etc.) _____

Any health problems during pregnancy (gest. diabetes, pre-eclampsia, bed rest, etc.) _____

Any medications, drugs or vitamins taken during pregnancy _____ Did the birth parent smoke _____

LABOR AND DELIVERY

Type of birth: ☐ Vaginal ☐ Planned C-Sect ☐ Emergency C-Sect ☐ Forceps ☐ Vacuum Ext ☐ Home Birth

Name of Hospital/Delivery Center _____ Length of stay _____

Length of labor _____ Length of pushing _____ Was labor induced ☐ Yes ☐ No # weeks into pregnancy at delivery (ex:38.4) _____

Baby's birth weight _____ Birth length _____ Problems during or after labor and delivery with parent or baby ___

_____

CHILD'S HEALTH HISTORY

Health problems with the child now or in the past _____ Surgeries _____

Accidents or injuries to the child (falls, car, sports, broken bones) _____ Amount screen time/day _____

Current medications or vitamins _____ Current behavior _____

Number of hours of sleep per night _____ Number of naps/day _____ Quality of sleep _____

Is your child developmentally appropriate/meeting milestones for their age _____

Concerns _____

_____

CHILD'S FEEDING HISTORY

Was the child breast fed _____ If so, for how long _____ Difficulty Nursing ☐ Yes ☐ No

Was the child bottle fed _____ If so, for how long _____ Tongue or oral ties ☐ Yes ☐ No ☐ Repaired ☐ Unsure

Current milk: ☐ Breast ☐ Formula/Brand _____ ☐ Cow's milk ☐ Soy milk ☐ Rice milk

☐ Plant milk ☐ Other _____

Frequency of eating _____ Current favorite food/snacks _____

Any known food or environmental allergies/intolerances _____

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PLEASE CHECK SYMPTOMS CHILD HAS OR HAS HAD IN THE PAST YEAR

GENERAL	EYE, EAR, NOSE, THROAT	GI / GU	ORTHO
☐ ADHD-hyperactive/impulsive	☐ Bad breath	☐ ARFID	☐ Abnormal crawl pattern
☐ ADHD-inattentive	☐ Chronic cough	☐ Bladder trouble	☐ Abnormal walk pattern
☐ Allergies	☐ Chronic sinus issues	☐ Bloating/Gas	☐ Bowed legs
☐ Anemia	☐ Dark circles under eyes	☐ Bowel changes	☐ Club foot
☐ Anger Issues	☐ Earache/infection	☐ Colic	☐ Congenital hip dysplasia
☐ Anorexia/Bulimia	☐ Eyes crossed	☐ Constipation	☐ Crawling concerns
☐ Anxiety	☐ Frequent runny nose	☐ Diarrhea	☐ Dislocated elbow
☐ Arthritis	☐ Hay fever/allergies	☐ Excessive hunger	☐ Flat head
☐ Autism Spectrum Disorder	☐ Hearing loss/hearing aid	☐ Excessive thirst	☐ Erb's Palsy
☐ Bed wetting	☐ Nosebleeds	☐ Food restriction/poor appetite	☐ Headaches
☐ Behavioral problems	☐ Pink Eye	☐ Hernia	☐ Head Preference
☐ Broken bones	☐ Postnasal drip	☐ Indigestion/excess gas	☐ Helmet use
☐ Bruise easily	☐ Ringing in ears	☐ Incontinence-bladder	☐ Jaw tension
☐ Cancer	☐ Sinus Congestion/stuffy nose	☐ Incontinence-colon	☐ Knock Knees
☐ Delayed milestones	☐ Snoring	☐ Kidney disease	☐ Neck Stiffness
☐ Depression	☐ Shortness of breath	☐ Nausea	☐ Toeing in or out
☐ Diabetes	☐ Speech delay	☐ Painful Urination	☐ Toe walking
☐ Dyslexia	☐ Strep throat	☐ Rectal Bleeding	☐ Torticollis
☐ Epilepsy	☐ Swallowing difficulties	☐ Reflux/GERD	☐ Sacral dimple
☐ Epi pen use	☐ Tongue tie/lip tie/cheek tie	☐ Stomach Pain	☐ Scoliosis
☐ Fainting spells	☐ Vision problems	☐ UTI	☐ Skipped crawling
☐ Growing pains	SKIN	☐ Vomiting	☐ Pain -please list area(s) of complaint:
☐ Heart Problems	☐ Baby acne		
☐ Hyperactivity	☐ Bruises easily	RESPIRATORY	
☐ Learning Disorder	☐ Bumps on back of arms	☐ Asthma	
☐ Nightmares	☐ Cradle cap	☐ Bronchitis	
☐ Night Sweats	☐ Eczema	☐ Colds/Flu	☐ OTHER
☐ Psychiatric Care	☐ Hives/rash/itching skin	☐ Cough	
☐ Seizure Disorder		☐ Covid	
☐ Sensory Processing Disorder	CARDIO	☐ Inhaler or Nebulizer used	
☐ Speech Delay or problem	☐ Chest pain		
☐ Spina Bifida	☐ Heart defect		
☐ Trouble sleeping	☐ Heart murmur		

The patient information given for this minor is true and complete to my knowledge. I accept responsibility for payment for services rendered. I authorize the doctor to take progress photos of my child to update other members of their medical team or to present during medical lectures.

Name of Patient (please print) _____ Child's date of birth _____

Name of Parent/Guardian (please print) _____ Relationship _____

Signature of Parent/Guardian _____ Today's date _____

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PATIENT FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, AND CONSENT FOR TREATMENT

Thank you for choosing Winchester Chiropractic Center (herein after referred to as "WCC") as your child's health care 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.

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.

No Show / Late Cancel Policy

A $25 surcharge will be applied to your balance if you (or your dependent) do not arrive for an 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 (or your dependent's) insurance card for our files. It is your responsibility to inform us of any change in your insurance coverage. WCC participates in most insurance plans. In order to properly bill your insurance company, we require all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient / guarantor responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any co- insurance, deductibles or non-covered services not paid by your insurance.

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.

Referrals and Authorizations

For the insurance carriers where WCC is a participating provider, it is our policy to implement and follow the referral and prior authorization guidelines set by the carrier. We will make every effort to inform you of your insurance requirements. However, it is ultimately your responsibility to know and understand what is required by your specific policy. Specific information regarding authorization requirements can be found in your policy benefits. However, if you have questions, please reach out to the member services number printed on the back of your insurance card.

Non-Covered Services

We pride ourselves on providing exceptional care and an extensive range of services for our patients. Some insurance companies choose not to pay for recognized service codes and apply these services to a patient's deductible. Any non-covered service is your responsibility. This can include, but is not limited to, oral or body myofascial release, oral or body myofunctional therapy, exercises, neuromuscular reeducation, craniosacral therapy, lactation related patient education, ultrasound, or laser therapy. If not covered, you will be responsible for those charges according to your health care insurance plan.

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ACKNOWLEDGEMENT OF PATIENT FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, AND CONSENT FOR TREATMENT

CHIROPRACTIC MANAGEMENT OF THE PEDIATRIC PATIENT MAY INCLUDE

- Indentification and reduction of vertebral subluxation(s)
- Age-appropriate pediatric manipulation/spinal adjustments to be performed by applying gentle and specific hands-on force to correct and/or reduce subluxation(s) -modified from adult procedures based on pediatric anatomy
- Offer advice about nutrition and exercise appropriate to their specific condition
- In-clinic rehabilitation and soft tissue techniques
- Referral to another health provider if required

BENEFITS: less tension in the myofascial system, improved posture and head control, improved developmental milestones, and restoration of normal movement patterns of the spine, pelvis and/or jaw.

RISKS: I understand and am informed that, as in practice of all forms of healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to fractures, bruising and sprains.

ALTERNATIVES: Medical care, rest, parent administered over the counter analgesics, physical therapy or occupational therapy.

CONSENT FOR TREATMENT

Children under the age of 18 are not permitted to give consent for their own medical procedures and treatments. When a pediatric patient (0-18 years of age) presents for care, it is essential for both chiropractor and patient/their guardian to work toward the same objective.

☐ I authorize the doctor to hold and examine my infant/child. If required, they may evaluate my baby's suckling motions by touching baby's mouth while wearing gloved hands. Winchester Chiropractic Center's physicians may perform a chiropractic treatment which is deemed necessary as was discussed.

☐ All questions regarding the doctor's approach to my child's care in this office have been answered to my complete satisfaction. I understand that the results are not guaranteed. I have read and fully understand the above statements and therefore accept chiropractic care for my child/ward on this basis.

☐ I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and/or staff under the direction and supervision of the Chiropractor(s) involved in my child's case.

Name of Patient (please print) _____ Child's date of birth _____

Name of Parent/Guardian(please print)_____ Relationship_____

Signature of Parent/Guardian_____ Today's date _____

PATIENT FINANCIAL RESPONSIBILITY

I acknowledge that I have read the above and am responsible for services rendered by Winchester Chiropractic Center, LLC. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in. I authorize WCC to release information to insurance carriers responsible for my or my dependent's care. I authorize my insurance company to pay directly to WCC all medical benefits for payment of services rendered. I have voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary. During treatment, I understand and acknowledge that no warranty or guaranty 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, or I am the parent/guardian of the patient.

Name of Patient (please print) _____ Date of Birth _____

Name of Parent/Guardian (please print)_____ Relationship to Patient _____

Signature of Parent/Guardian _____ Today's Date _____

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NO-SHOW POLICY

This policy is to ensure patients have access to care when needed. You will be billed $25 if your child misses an 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 Patient (please print) _____ Date of birth _____

Name of Parent/Guardian(please print)_____ Relationship to Patient _____

Signature of Parent/Guardian_____ Today's date _____

NOTICE OF PRIVACY PRACTICES-HIPAA

We are concerned with protecting your child's 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 Patient (please print) _____ Date of birth _____

Name of Parent/Guardian(please print)_____ Relationship to Patient _____

Signature of Parent/Guardian_____ Today's date _____

LACTATION RELATED SERVICES

If your child is having difficulties feeding at the breast, we may need to examine both the lactating parent as well as the infant and take a detailed history of the complaints. We 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. 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. If lactation services are needed beyond the initial examination, we will determine if insurance will cover the consultation or if you will be required to pay out of pocket and receive a superbill to submit to your insurance. 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. 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.

Name of Lactating Parent (please print) _____ Relationship to Patient _____

Signature of Parent/Guardian _____ Today's Date _____

Reset Submit