TRANSFORMATION
Chiropractic & Wellness Center LLC

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970-812-5559

Welcome to Transformation Chiropractic & Wellness Center LLC where your health transformation is our passion! When a patient seeks chiropractic health care with us it is important that each patient understands both the objective and the method that will be used to attain it.

We do not offer to diagnose or treat any disease. Our focus is the diagnoses of vertebral subluxations, neuro-musculoskeletal conditions, or dietary and nutritional issues. If during the course of care we encounter a non-chiropractic or unusual finding we will advise you. If a referral is appropriate we will recommend you seek the services of the appropriate health care provider.

Our practice objective is to eliminate major interference to your body's expression of innate healing. We will employ specific adjusting to correct vertebral subluxations and any other procedures or recommendations necessary to help your body maintain its adjustment and heal efficiently.

PATIENT INFORMATION

Please complete complete all questions so we can better serve you.

First Name | Middle Initial | Last Name

Nick Name | SSN

Gender ☐ Male ☐ Female | Date of Birth

Email

Martial Status
☐ Married ☐ Single ☐ Divorced ☐ Widowed

Street Address | Home Phone

City | Work Phone

State | Zip Code | Cell Phone

Employment Status ☐ Employed ☐ Self-Employed ☐ Student ☐ Retired ☐ n/a

Occupation | Employer / School

Address

Work Phone | Is it okay to call you at work ☐ **Yes** ☐ **No**

SPOUSE INFORMATION

Is your spouse a patient of this clinic ☐ **Yes** ☐ **No**

First Name | Middle Initial | Last Name

Work Phone | Cell Phone

How did you hear / who referred you to our clinic?

In general, would you say your overall health is….

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

List any traumas and their dates:

List any broken bones or dislocations:

Surgeries / Year:

☐ Appendectomy _____ ☐ Arthroscopy _____ ☐ Brain Surgery _____

☐ C-Section _____ ☐ Cardiovascular procedure _____ ☐ Cervical disc procedure _____

☐ Hysterectomy _____ ☐ Gallbladder Removal _____ ☐ Joint replacement _____

☐ Laminectomies _____ ☐ Prostate surgery _____ ☐ Other

Allergies / Sensitivities:

☐ Alcohol ☐ Casein ☐ Cat / Dog ☐ Corn ☐ Dust

☐ Eggs ☐ Fish ☐ Gluten ☐ Grass ☐ Shellfish

☐ Milk or Lactose ☐ Nightshades ☐ Nuts ☐ Peanut ☐ Pollen

☐ Soy ☐ Sulfites ☐ Wheat ☐ Yeast ☐ Other

Family History:

☐ Arthritis (parent) ☐ Arthritis (sibling) ☐ Cancer (parent) ☐ Cancer (sibling)

☐ Cholesterol (parent) ☐ Cholesterol (sibling) ☐ Diabetes (parent) ☐ Diabetes (sibling)

☐ Heart problems (parent) ☐ Heart problems (sibling) ☐ High blood pressure (parent)

☐ High blood pressure (sibling) ☐ Psychiatric (parent) ☐ Psychiatric (sibling)

☐ Stroke (sibling) ☐ Stroke (parent) ☐ Thyroid (parent) ☐ Thyroid (sibling)

☐ Other

Social History:

☐ Caffeine ☐ Chew tobacco ☐ Drink alcohol ☐ Smoke ☐ Other

Expanded Patient Health History:

General History

- [ ] Injuries / Car accident
- [ ] Height changes
- [ ] Weight changes
- [ ] Fever / Chills / Sweats
- [ ] HIV positive
- [ ] Allergies
- [ ] Anemia
- [ ] Bleeding / Bruising
- [ ] Malaise/ Fatigue/Weakness

Psychological / Learning

- [ ] Anxiety
- [ ] Autism
- [ ] Depression
- [ ] Dyslexia
- [ ] Dementia
- [ ] Hospitalization / Therapy
- [ ] Sneezing
- [ ] OCD

Endocrine System

- [ ] Heat/Cold intolerance
- [ ] Thyroid problems
- [ ] Diabetes
- [ ] Neck Surgery / Irradiation
- [ ] Hormone Therapy

Eye/Ear/Nose/Throat

- [ ] Visual problems
- [ ] Eye irritation
- [ ] Pain in eyes
- [ ] Other eye problems
- [ ] Difficulty hearing / Deaf
- [ ] Ringing in ears / Dizziness
- [ ] Ear growths / Discharge
- [ ] Ear Pain
- [ ] Nosebleeds
- [ ] Change in ability to smell
- [ ] Abdominal pain
- [ ] Nose growths / Discharge

- [ ] Nose pain
- [ ] Sinusitis
- [ ] Other nose problems
- [ ] Hoarseness
- [ ] Change in voice
- [ ] Difficulty swallowing
- [ ] Enlarged glands
- [ ] Change in taste
- [ ] Dental problems
- [ ] Growth / Lesions
- [ ] Other

Gastrointestinal System

- [ ] Change in appetite
- [ ] Food intolerance
- [ ] Nausea / Vomiting
- [ ] Peptic ulcer
- [ ] Indigestion/Heartburn
- [ ] Other tobacco use
- [ ] Abdominal swelling

- [ ] Gas
- [ ] Change in stool color
- [ ] Diarrhea / Constipation
- [ ] Hernia
- [ ] Hemorrhoids
- [ ] Gallbladder problems
- [ ] Liver disease
- [ ] Pancreatitis
- [ ] Alcohol intake

Respiratory System

- [ ] Difficulty breathing
- [ ] Cough
- [ ] Blood in sputum
- [ ] Wheezing / Asthma
- [ ] Tuberculosis / Exposure
- [ ] Pneumonia / Lung infection
- [ ] Cigarette Smoke Exposure
- [ ] Toxic fume exposure

Doctor's Notes:

Expanded Patient Health History Continued:

Cardiovascular System

- ☐ Shortness of breath
- ☐ Chest discomfort / Pain
- ☐ Palpitations
- ☐ Edema / Swelling
- ☐ Fainting
- ☐ Calf pain while walking
- ☐ High / Low Blood Pressure
- ☐ Heart disease
- ☐ Cardiovascular surgeries
- ☐ Other problems

Urinary System

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Changes in color
- ☐ Difficulty starting
- ☐ Difficulty holding
- ☐ Discharge / Blood
- ☐ Urinary tract infections
- ☐ Kidney disease
- ☐ Flank pain
- ☐ Pelvic pain
- ☐ Pelvic mass
- ☐ Other problems

Breasts

- ☐ Bumps/Lumps/Tenderness
- ☐ Dimples in breast
- ☐ Changes in color / size
- ☐ Nipple discharge
- ☐ Other problems

Reproductive System

- ☐ Genital lesion / Sores
- ☐ Genital mass / growth / pain
- ☐ Syphilis
- ☐ Prostate exam in last year
- ☐ Gonorrhea
- ☐ Change in sex drive
- ☐ Pain during sex
- ☐ Birth control
- ☐ Other sexual difficulties

Skin / Hair / Nails

- ☐ Change in skin temperature
- ☐ Change in skin texture
- ☐ Eczema
- ☐ Mole changes
- ☐ Rashes / Itching / Sores
- ☐ Skin dryness / wetness
- ☐ Skin growths
- ☐ Skin pain
- ☐ Skin sensitivity
- ☐ Change in hair texture
- ☐ Change in hair growth / loss
- ☐ Change in shape fingernails
- ☐ Change in color of fingernails
- ☐ Change in shape of toenails
- ☐ Change in color of toenails
- ☐ Other problems

Neurological System

- ☐ Headaches
- ☐ Epileptic seizures
- ☐ Tics / Spasms
- ☐ Dizziness / Fainting
- ☐ Disturbance of sensation
- ☐ Unusual weakness
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Other problems

Musculoskeletal System

- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Muscles weakness
- ☐ Muscle wasting
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Sacroiliac pain
- ☐ Tailbone pain
- ☐ Arm problem
- ☐ Leg problem
- ☐ Fractures / Dislocations
- ☐ Sprains / Strains
- ☐ Other injuries
- ☐ Other problems

Diet / Vitamins

- ☐ Eat meals sporadically
- ☐ Unusual appetite
- ☐ Skip meals
- ☐ Eat between meals
- ☐ Eat late night snack
- ☐ Eat processed food
- ☐ On special diet
- ☐ Vegetarian
- ☐ Taking supplements

Implants

- ☐ Breast implants
- ☐ Cardiac pacemaker/Etc.
- ☐ Penile implant
- ☐ Other implant

Cancers

- ☐ Breast
- ☐ Colon
- ☐ Lung
- ☐ Prostate
- ☐ Skin
- ☐ Thyroid
- ☐ Other

Please describe your main complaints

Please describe how and when this began

Is there anything that makes your symptoms worse?

Is there anything that makes your symptoms better?

Does the pain radiate or travel to any other part of your body? ☐ Yes ☐ No

Where?

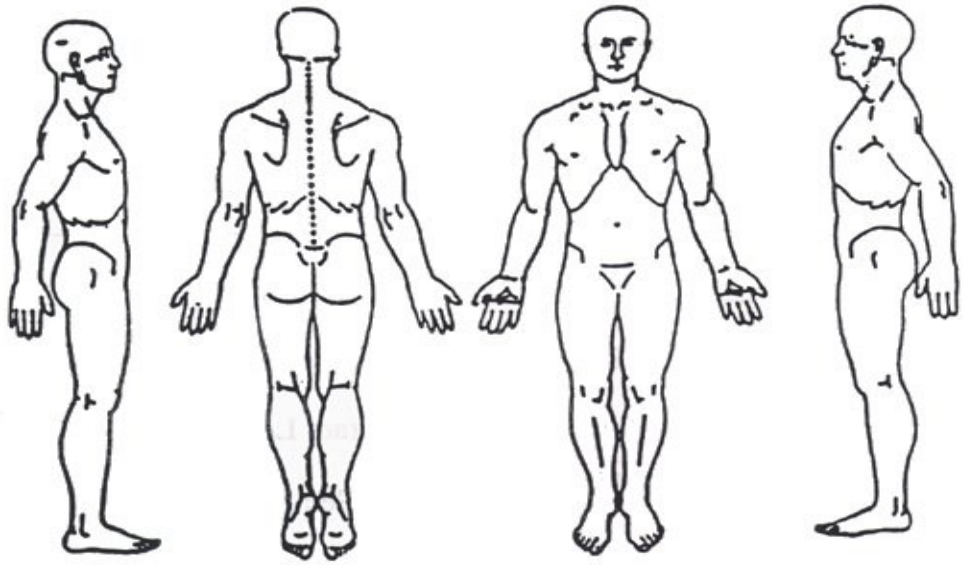
If applicable please indicate the location and type of symptom you are experiencing

Please mark on the diagram after you have printed the document

Numbness	= = = = =	Burning	x x x x x
Pins/Needles	o o o o o	Stabbing	/ / / / /
Aching	a a a a a	_____	# # # # #

(Please describe the symptom)

Please indicate the severity of pain (Scale 1-10, 10 being unbearable) for the symptoms diagrammed



How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ☐ Sharp
- ☐ Dull ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling
- ☐ Stabbing

How are your symptoms changing?

- ☐ Getting better
- ☐ Not changing
- ☐ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

☐ 0 None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and at home):

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

Who have you seen for your symptoms:

- ☐ No one
- ☐ Other Chiropractor
- ☐ Medical Doctor
- ☐ Physical Therapist
- ☐ Other _____

What treatment did you receive for your symptoms?

- ☐ Adjustments
- ☐ Physical Therapy
- ☐ Medication
- ☐ Surgery
- ☐ Other _____

What tests have you had for your symptoms?

- ☐ X-rays
- ☐ MRI
- ☐ CT Scan
- ☐ Other _____

Have you had similar symptoms in the past? ☐ Yes ☐ No

Please use this space to further describe any of the conditions / symptoms checked or listed previously or any health issue that you are concerned about:

For female patients only:

At what age / year did you first start your 1st period?

Average length of cycle (days) Average length of period (days)

Menstrual Cramping:

0 1 2 3 4 5

Menstrual Flow:

Scant Light Moderate Heavy

Have you every been pregnant? Yes No

Number of live births **Miscarriages** Yes No

Post menopausal bleeding

Abnormal / Painful premenstrual fluid retention

Hysterectomy

Difficult delivery

Other female problems

PMS

Please rate your level of physical activity:

Not active. You do less than 30 minutes of light activity no more than 2 times a week. Cleaning house, slow walking, and playing golf are examples of light activity.

Moderately active. You do up to 30 minutes of light to moderate activity 3 to 5 times a week. Brisk walking, jogging, riding a bike, swimming, and playing tennis are examples of moderate activity.

Very active. You do more than 30 minutes of moderate activity at least 5 times a week.

Activities you participate in or enjoy:

Have you or are you currently experiencing acute (short term) or chronic (long term) stress; please specify?

Do you sleep with a cervical or contour pillow? ☐ **Yes** ☐ **No**

Please list all medications (prescription or OTC) and supplements you are currently taking:

Name of medication / Supplement	*Dosage*	*Reason for taking*

* If additional space is needed please attach a separate sheet with remaining medications / supplements *

To provide the best care possible for our patients, do we have permission to share updates on your progresses, when appropriate, with your doctor(s)? ☐ **Yes** ☐ **No**

Name / Title	*Address*	*Phone number*

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Informed Consent For Chiropractic Care

Chiropractic care, like all forms of healthcare, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with a chiropractic adjustment are extremely rare.

Prior to receiving chiropractic care at Transformation Chiropractic & Wellness Center LLC, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and your spinal health. Theses procedures will assist the doctor in determining if chiropractic care is needed, or if any further examination or studies are needed before treatment. In addition, they will help the doctor determine if there is any reason to modify your care or provide you with a referral to another health care provider. Prior to chiropractic care, all relevant findings will be reported to you to assist you in your decision in becoming a healthier individual.

There are different treatment options available for common conditions that present to a chiropractic office other than chiropractic procedures. These treatment options include, but are not limited to self-administered over the counter medication and rest; medical care with prescription drugs, physical therapy, steroid injections, bracing, and surgery. Chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations allowing the body to return to improved health. Chiropractic can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure.

I understand and accept that there are risks associated with chiropractic and give my consent to the examination that the doctor deems necessary and to the chiropractic care, including spinal adjustments and other modalities, as reported following my assessment. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

Name	Witness Name (office staff)
Patient or legal Guardian Signature	Witness Signature (office staff)
Date	Date

TRANSFORMATION
Chiropractic & Wellness Center LLC
Dr. Andrea Jordheim, D.C.
2501 Blichmann Ave. Suite 110
Grand Junction, CO 81505

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

My signature acknowledges that I have received a copy of the Transformation Chiropractic & Wellness Center LLC HIPAA Privacy Policy

Name

Signature

Date

If you are a minor or being represented by another party:

Name

Signature

Date

Description of authority to act on behalf of patient

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)