TRANSFORMATION
Chiropractic & Wellness Center LLC

2501 Blichmann Ave. Suite 110, Grand Junction, CO 81505
Info@TransformationChiropractic.com
970-812-5559

PEDIACTRIC NEW PATIENT PACKET

* For children ages newborn to 8 years *

Welcome to Transformation Chiropractic & Wellness Center LLC where our objective is to ensure the integrity of your child's nervous system. 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 for your child will advise you. If a referral is appropriate we will recommend your child seek the services of the appropriate health care provider.

CHILD'S INFORMATION

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

First Name _____ Middle Initial _____ Last Name _____

Nick Name _____

Gender ☐ Male ☐ Female Date of Birth _____

Street Address _____

City _____ Home Phone _____

State _____ Zip Code _____ Parent Email _____

MOTHER'S INFORMATION

Is the mother a patient of this clinic ☐ Yes ☐ No

First Name _____ Middle Initial _____ Last Name _____

Work Phone _____ Cell Phone _____

FATHER'S INFORMATION

Is the father a patient of this clinic ☐ Yes ☐ No

First Name _____ Middle Initial _____ Last Name _____

Work Phone _____ Cell Phone _____

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

Authorization for Care of a Minor

I hereby authorize this office and its Doctor to administer care as is deemed necessary to my son/daughter/ward (upon approval of parent or guardian)

Parent or Legal Guardian Name

Parent or Legal Guardian Signature

Description of authority to act on behalf of patient

Date

I understand that I am responsible for all fees charges by this office for the care of this child. I agree to pay for all services provided.

Signature

Date

Pediatrician / Family Doctor

Name

Office name

Office Address

Office Phone

Date of last visit **:**

Reason for last visit **:**

Immunization History:

Has your child been immunized? ☐ **Yes** ☐ **No**

Are they up to date? ☐ **Yes** ☐ **No**

If so, when was their last immunization and which one?

Has your child ever been treated on an emergency basis? ☐ **Yes** ☐ **No**
If YES, please explain.

Purpose of this Appointment
What is the child's main complaint? Describe. ☐ **Your Words** ☐ **Your Child's Words**

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

List any traumas and their dates:

List any broken bones or dislocations:

List any surgeries / Year:

Birth Weight **Birth Length** **Current Weight** **Current Length/Height**

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 (parents or siblings)

☐ Allergies ☐ Anxiety ☐ Autism ☐ Autoimmune Disease
☐ Cancer ☐ Depression ☐ Diabetes ☐ Digestive disorders
☐ Dyslexia ☐ Food sensitivities ☐ Heart disease ☐ High Blood Pressure
☐ Immune compromise ☐ OCD ☐ Psychiatric disorder ☐ Skin Disorders
☐ Thyroid disorder ☐ Stroke ☐ Other

Prenatal History

Did the Mother:

If yes to any please explain.

Take any medication? ☐ Yes ☐ No

Smoke or consume alcohol? ☐ Yes ☐ No

Experience any illness? ☐ Yes ☐ No

Delivery / Birth History

How long was the labor? _____ Hours

Were forceps or vacuum extraction used? ☐ Yes ☐ No

Was the labor induced? ☐ Yes ☐ No

Was the delivery premature? ☐ Yes ☐ No

Was a c-section performed? ☐ Yes ☐ No If yes, at _____ months and _____ days

Check any of the following that your child experienced immediately after their birth:

☐ Jaundice ☐ Displaced or broken bones ☐ Other: _____

☐ Feeding Problems ☐ Respiratory Issues

Infant / Childhood History

Infant feeding:

☐ Breast-fed ☐ Bottle-fed

If bottle-fed, which formula?

Does the child have trouble feeding on one side vs. the other? If yes, please explain. Do you have any breast feeding concerns?

Average hours of sleep per night _____ Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Nutrition:

Please check if the child has consumed any of the following:

☐ Breast milk ☐ Solid food ☐ Supplements

☐ Commercial formula ☐ Sweets ☐ Medications

☐ Homeopathic medicine ☐ Herbs ☐ Fruit juice

☐ Cow's milk ☐ Goat's milk ☐ Soda

☐ Soy milk ☐ Almond milk ☐ Other: _____

Pediatric Milestones

At what age did your child:

Respond to sound ____

Follow an object with his/her eyes ____

Hold head up ____

Sit ____

Crawl ____

Walk ____

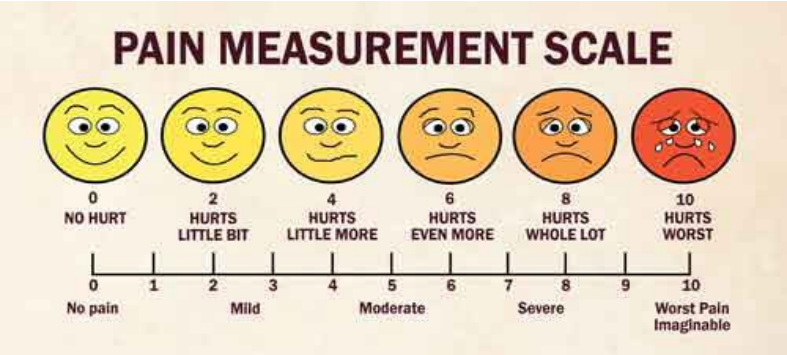
Has your child ever had or currently have:

- [ ] ADD / ADHD
- [ ] Allergies
- [ ] Anemia
- [ ] Arm problems
- [ ] Asthma
- [ ] Autism
- [ ] Backaches
- [ ] Bed wetting
- [ ] Behavioral problems
- [ ] Broken bone
- [ ] Chickenpox
- [ ] Colds / Flu
- [ ] Colic
- [ ] Constipation
- [ ] Diabetes
- [ ] Digestive disorders
- [ ] Diptheria
- [ ] Dizziness
- [ ] Dyslexia
- [ ] Earaches/infection
- [ ] Fainting
- [ ] Growing pains
- [ ] Headaches
- [ ] Heart troubles
- [ ] Hypertension
- [ ] Hyperglycemia
- [ ] Hypoglycemia
- [ ] Joint problems
- [ ] Leg problems
- [ ] Mononucleosis
- [ ] Mumps
- [ ] Muscle pain
- [ ] Muscle spasm
- [ ] Muscle tone issues
- [ ] Muscle weakness
- [ ] Nervousness (excessive)
- [ ] Neck Problems
- [ ] Orthopedic issues
- [ ] Polio
- [ ] Poor appetite
- [ ] Poor posture
- [ ] Psoriasis
- [ ] Reflux
- [ ] Rubella
- [ ] Robeola / Measles
- [ ] Ruptures / hernia
- [ ] Scoliosis
- [ ] Seizure / convulsions
- [ ] Sinus issues
- [ ] Stomachaches
- [ ] Tetanus
- [ ] Walking troubles
- [ ] Whooping cough
- [ ] Worries (excessive)
- [ ] Other: ____

Has your child ever:

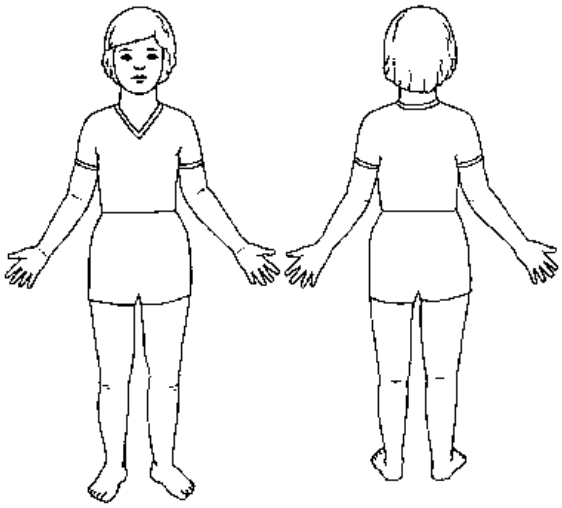
- [ ] Fallen in baby walker
- [ ] Fallen off a swing
- [ ] Fallen from crib
- [ ] Fallen off a slide
- [ ] Fallen from highchair
- [ ] Fallen off skateboard
- [ ] Fallen from changing table
- [ ] Fallen from bed or couch
- [ ] Fallen off a bicycle
- [ ] Fallen down stairs
- [ ] Used a hanging baby jumper
- [ ] Other: ____

Reason For Visit Continued



Please indicate the region and severity of pain below:

Please describe your child's main complaint, how and when it began



Please mark on the diagram after you have printed the document

Type of Pain

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

How often does your child experience these 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 child's symptoms?

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

How are your child's symptoms changing?

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

Please indicate any non-musculoskeletal / system issues your child is experiencing

Please rate your child's level of physical activity:

- ☐ **Not active.** Your child does less than 30 minutes of light activity no more than 2 times a week. Watching TV, playing video games, and slow walking are examples of light activity.
- ☐ **Moderately active.** Your child does up to 30 minutes of light to moderate activity 3 to 5 times a week. Brisk walking, jogging, riding a bike, swimming, and playing soccer are examples of moderate activity.
- ☐ **Very active.** Your child does up to 30 minutes of moderate activity at least 5 times a week.

What activities or sports does your child like to participate in?

Please list all medications (prescription or OTC) and supplements your child is 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 child's progresses, when appropriate, with his or her doctor(s)? ☐ Yes ☐ No

Name / Title	*Address*	*Phone number*

TRANSFORMATION
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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.

Parent of Legal Guardian Name

Witness Name (office staff)

Parent 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

Child Name

Parent or Legal Guardian Name

Date

Parent or Legal Guardian Signature

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)