TRANSFORMATION
Chiropractic & Wellness Center LLC

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

Personal Injury / MVA New Patient Packet

We will accept assignment of your claim if the following criteria have been met within 2 weeks of your initial visit to our office. If these requirements are not all met for any reason, any outstanding balance becomes due in full and the cost of future care id due at the time of service until other arrangements are made with this office.

Accident Information
The following must be on file in our office:

- The name, address, and phone number to the insurance carrier for the vehicle that you were in as well as the policy holder's name.
- A copy of your health and car insurance cards if applicable
- The name, address, and phone number of your attorney, if applicable
- A copy of the police report, if applicable
- Assignment of benefits form

Additional Information

- If you are sent to an independent medical examiner (IME/QME) please notify the office immediately.
- If you are receiving care from any other office please notify this office immediately.

If for any reason the insurance company denies payment of your chiropractic bills, even though all our office criteria has been met, you are ultimately responsible for the payment of your bills.

I HAVE READ THE ABOVE STATEMENTS AND AGREE TO ALL THE TERMS OF THESE STATEMENTS.

Signature ____________________ Date __________

Assignment of Benefits

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint TRANSFORMATION CHIROPRACTIC & WELLNESS CENTER LLC and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and TRANSFORMATION CHIROPRACTIC & WELLNESS CENTER LLC which checks, drafts or money orders are made payable for services which have been made by TRANSFORMATION CHIROPRACTIC & WELLNESS CENTER LLC, at the request of with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes but is not limited to, all rights to collect benefits directly from my insurance company for services that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the provider as my assignee.

The undersigned by these presents does give and grant TRANSFORMATION CHIROPRACTIC & WELLNESS CENTER LLC as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document.

At any time after Insurer fails to render the applicable payment within 30 days upon receipt of Health Care Providers medical bills got any date of service, this agreement may be revoked.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, ____________________, hereby authorize ____________________

(name of insured) (name of insurance company)

to pay to and mail directly to TRANSFORMATION CHIROPRACTIC & WELLNESS CENTER LLC the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to TRANSFORMATION CHIROPRACTIC & WELLNESS CENTER LLC and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Colorado Statutes for any services and charges provided by TRANSFORMATION CHIROPRACTIC & WELLNESS CENTER LLC

Patient or Legal Guardian Signature	Patient Name	Date

☐ Check if not applicable

TRANSFORMATION CHIROPRACTIC & WELLNESS CENTER LLC
LIEN

I, ____________________, fully understand that I am directly and fully responsible to Transformation Chiropractic & Wellness Center LLC for all expenses submitted for service and goods rendered me, and that this agreement is made only for protection and consideration while awaiting payment, to avoid penalties or interest being charged to my account. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

This LIEN EXPIRES on ____________________. Once lien expires, it is THE PATIENT'S responsibility to make billing/payment arrangements or pay outstanding balance within 30 days or negotiate another lien period, to avoid further charges and collection proceedings.

If an attorney is obtained I, ____________________ will immediately notify Transformation Chiropractic & Wellness Center LLC and will authorize my attorney to issue direct payment to Transformation Chiropractic & Wellness Center LLC for the total sum of balance(s) outstanding for treatment rendered to me at the office of Dr. Andrea Jordheim, D.C. for injuries sustained in the accident on ____________________.

Date ____________________

Patient Name ____________________

Patient Signature ____________________

Doctor Signature ____________________

☐ Check if not applicable

HEALTHCARE POWER OF ATTORNEY

By this power of attorney I, ____________ (hereinafter, "Principal") of ____________, County of ____________, in the state of
(City)
Colorado, do appoint Transformation Chiropractic & Wellness Center LLC (hereinafter, "Attorney"), as my true and lawful attorney in fact. In Principal's name, and for Principal's use and benefit, said attorney is hereby authorized to:

1. Endorse any and all checks or forms of reimbursement made payable to principal (or members of principal's family) by any health insurance companies which relate to medical treatment provided by attorney to principal (or members of principals family) over to attorney.

2. Demand and direct any and all health insurance companies, during the course of principal's (or member of principal's family) medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and to send such checks directly to attorney. This Special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare services provided and shall be irrevocable throughout the duration of the healthcare services provided by Attorney to Principal arising from any injury or major medical conditions sustained either by Principal or members of Principal's family.

3. GIVING AND GRANTING to said attorney full power and authority to do all and everything whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might or could do if personally present.

4. I authorize Transformation Chiropractic & Wellness Center LLC to represent my interests in any and all disputes when payment for my claims have not been paid in part or in full. I authorize Transformation Chiropractic & Wellness Center LLC to represent me in the event a compliant must be made to the Colorado Insurance Commissioner.

All that said Attorney shall lawfully do or cause to be done under the authority of this power of attorney is expressly approved.

Date ____________

Patient Name ____________

Patient Signature ____________

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? ______

Automobile Accident Information

Date of Accident ______ Time of Accident ______

Please Describe the accident in your own words:

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the vehicle? ______

Accident Site

Road/Street Name ______ **City/Sate** ______

Nearest Intersection ______ Direction Traveling ______

Speed Traveling ______ Driving Conditions: ☐ Dry ☐ Wet ☐ Icy ☐ other ______

Vehicle

Make and model ______

Wearing a seatbelt? ☐ None ☐ Lap ☐ Shoulder

Was the vehicle equipped with airbags? ☐ yes ☐ No

If so, did they deploy properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest? ☐ Low ☐ Middle ☐ High

Police

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Impact

Did your car impact another vehicle? ☐ Yes ☐ No If yes please explain:

Did your care impact a structure? ☐ Yes ☐ No

Did your body strike anything? ☐ Yes ☐ No

If yes please explain:

Was impact to the car from: ☐ Front ☐ Rear ☐ Left ☐ Right

At the time of impact were you:

☐ Looking straight ahead ☐ Looking up ☐ Looking down

☐ Looking right ☐ Looking left

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

After Impact

Did the accident leave you unconscious? ☐ Yes ☐ No If yes, how long?

Have you seen a doctor? ☐ Yes ☐ No

If yes, when did you go? ☐ Day of accident ☐ Next day ☐ More than 2 days

Did you go to the hospital? ☐ Yes ☐ No

How did you get there? ☐ Ambulance ☐ Private Transportation

Name of hospital / doctor:

What treatment did you receive?

Were x-rays taken? ☐ Yes ☐ No Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since injury? ☐ Yes ☐ No Work activities restricted ☐ Yes ☐ No

How many hours are in your typical work day? [ ]

Indicate daily job activities and duties which you are asked to perform:

☐ Standing ☐ Sitting ☐ Walking ☐ Lifting ☐ Driving ☐ Twisting ☐ Crawling

☐ Bending ☐ Operating Equipment ☐ Work with arms above head ☐ Typing ☐ Stooping

☐ Other: [ ]

Is your condition getting worse? ☐ Yes ☐ No

Frequency: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Rate your pain on a scale from 1 to 10 (10 being debilitating)

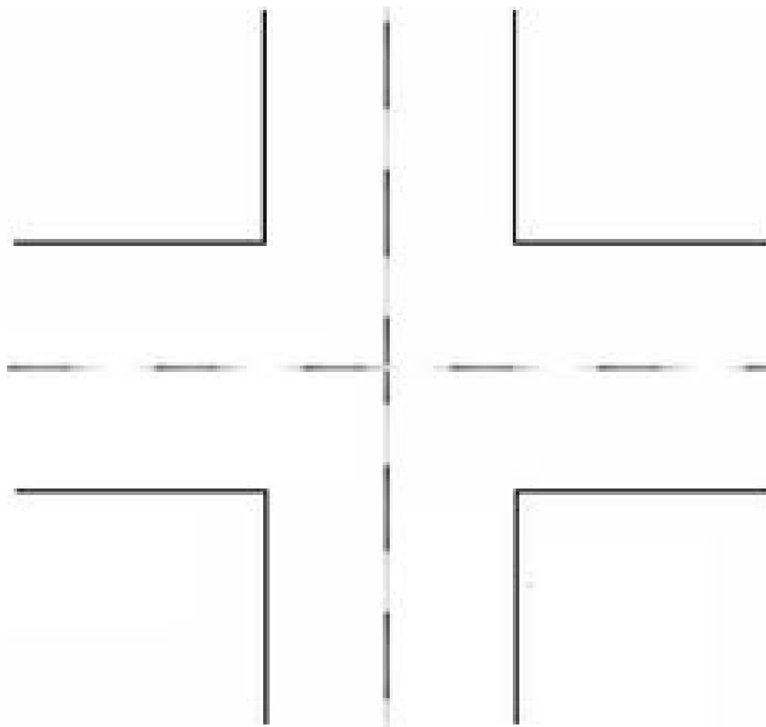
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Indicate your degree of comfort while preforming the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Sex	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Using the diagram below please indicate the following:

- Your care and what direction it was driving
- Other cars involved in the accident and their direction of travel
- Building, posts, road signs, trees, benches, and all other items near the site of the accident



Please describe the progression of the accident:

Please check the following symptoms you have experienced since the accident.

☐ Headache	☐ Painful breathing	☐ Eye Strain	☐ Loss of taste
☐ Skull or head pain	☐ Low back pain	☐ Difficulty focusing	☐ Cold sweats
☐ Neck pain	☐ Low back stiffness	☐ Pain behind your eyes	☐ Fever
☐ Neck stiffness	☐ Hip pain	☐ Eyes sensitive to light	☐ Swelling
☐ Head feels too heavy	☐ Buttock pain	☐ Double vision	☐ Difficulty in :
☐ Shoulder pain	☐ Leg pain	☐ Buzzing/ringing in ears	☐ Riding in car
☐ Shoulder stiffness	☐ Leg numbness	☐ Loss of balance	☐ Bending
☐ Arm pain	☐ Pins/needles in legs	☐ Heart palpitations	☐ Standing
☐ Arm numbness	☐ Cold feet	☐ Shortness of breath	☐ Sitting
☐ Cold hands	☐ Depression	☐ Digestive problems	☐ Walking
☐ Upper back pain	☐ Anxiety	☐ Nausea	☐ Lifting
☐ Upper back stiffness	☐ Tension	☐ Vomiting	☐ Twisting
☐ Mid back pain	☐ Irritability	☐ Diarrhea	☐ Turning
☐ Mid back stiffness	☐ Nervousness	☐ Constipation	
☐ Chest pain	☐ Mental dullness	☐ Excessive perspiration	
☐ Rib pain	☐ Loss of memory	☐ Loss of perspiration	

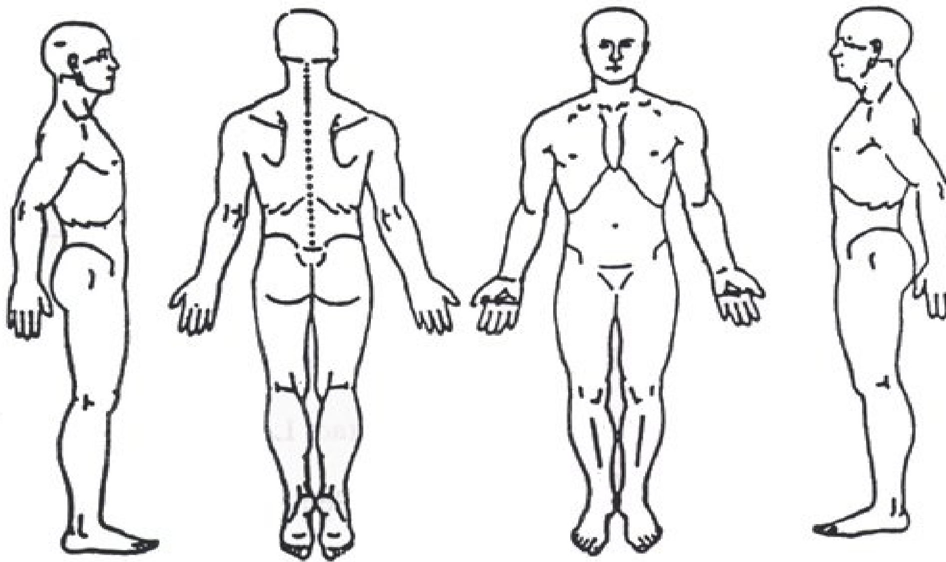
Reserved for Doctor's Notes:

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



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?

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 *

Please fill out the remaining forms to indicate your health condition and the musculoskeletal complaints you suffered from BEFORE the accident.

In general, before your accident 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 / Intolerance:

☐ 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 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
- [ ] Depression
- [ ] Hospitalization / Therapy
- [ ] 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
- [ ] Sneezing
- [ ] 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
- [ ] Abdominal pain
- [ ] 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
- [ ] Other tobacco use
- [ ] Toxic fume exposure

Doctor's Notes:

Expanded 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 list any previous conditions you were experiencing before your accident

Please describe how and when they began

How often did 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 before your accident?

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

During the past 4 weeks before your accident, 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 before your accident, how much did 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 before your accident, how much of the time did 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

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 before your accident:

☐ **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: ______

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

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*

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)