VOITENKO WELLNESS
CHIROPRACTIC NUTRITION

WELCOME
INTAKE FORM

13372 Newport Ave. Ste. D
Tustin, CA 92780
Office: **714.730.2225**
FAX: 714.730.2223

Date _____ **Whom may we thank for referring you?** _____

Patient Name _____ _____ _____
last name first name middle

Address _____

City _____ State_____ Zip_____ Cell Ph_____

Email _____ May we add you to our email list? ☐ Yes ☐ No
We do not share your information with anyone.

Sex ☐M ☐F Age_____ Birth date_____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for_____years

Employer/School _____ Occupation _____

Employer/School Address _____

City _____ State_____ Zip_____

Spouse's Name _____ Birth date _____

EMERGENCY CONTACT

Name_____ Relationship_____

Cell ph_____ Home ph_____

PATIENT CONDITION

Reason for visit _____

Is your condition due to an accident? ☐ Yes ☐ No Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident? ☐ Auto Ins ☐ Employer ☐ Worker Comp ☐ Other

When did your symptoms first appear?_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

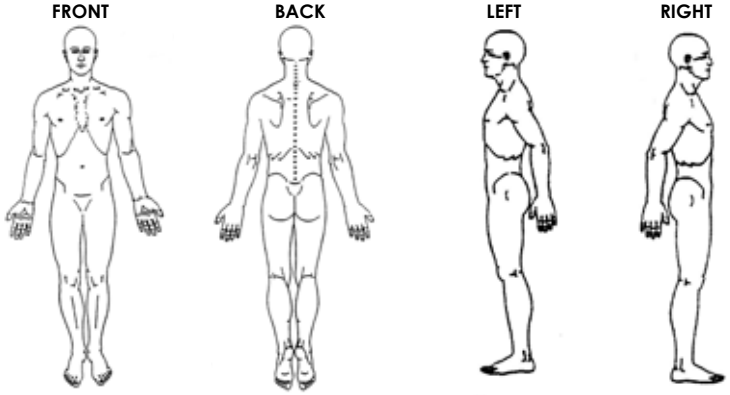
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____ Pain frequency is: ☐ Constant ☐ Occasional

Does the pain interfere with any of the following? ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

Please mark an X on the picture to the right where you continue to have pain, numbness and/or tingling.



HEALTH HISTORY

VOITENKO WELLNESS
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What treatment(s) have you already received for your condition?

☒ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

Name and Address of other doctor(s) that have treated you for this condition:

Dr. Name_____ Address_____ Ph_____

Dr. Name_____ Address_____ Ph_____

Dr. Name_____ Address_____ Ph_____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI_____ CT-Scan_____ Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Other_____
Chemical Dependency ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No	_____
Chicken Pox ☐ Yes ☐ No	Measles ☐ Yes ☐ No		
Diabetes ☐ Yes ☐ No			

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Packs/Day_____
- ☐ Alcohol — Drinks/Week_____
- ☐ Coffee/Caffeine Drinks — Cups/Day_____
- ☐ High Stress Level — Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had:

	Description	Date
Head injuries		
Broken bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy_____		
Pharmacy ph. _____		

HEALTH HISTORY (continued)

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Mark below any of the following symptoms you have experienced in the past 6 months.

☐ Low Back Pain	☐ Shoulder Pain	☐ Weight Trouble
☐ Neck Pain	☐ Hip Pain	☐ Tension Across the Top of Shoulders
☐ Pain Between Shoulder Blades	☐ Knee Pain	☐ Tingling / Numbing in Arms or Hands
☐ Tension / Headaches	☐ Ankle / Foot Pain	☐ Tingling / Numbing in Legs or Feet
☐ Tired or Fatigued	☐ Ringing in the Ears	☐ Dizziness
☐ Wrist / Hand Pain	☐ Allergies	☐ Nervousness
☐ Elbow Pain	☐ Digestive Troubles	☐ Difficulty Sleeping

Which one of the above symptom(s) is worse?_____

How long have you had the symptom(s) ?_____

When it is at its worst, how does it feel?_____

_____

_____

_____

_____

_____

Mark below how the symptom(s) cause you to act.

☐ Moody ☐ Irritable ☐ Interrupts Sleep ☐ Restrict daily activities ☐ Other_____

Mark below how the symptom(s) affect you at work.

☐ Decision making ☐ Exhausted at end of day ☐ Decreased productivity

☐ Poor attitude ☐ Unable to work long hours ☐ Other_____

Mark below how the symptom(s) affect you at home.

☐ Lose patience with others

☐ Hinders ability to exercise or participate in sports

☐ Restricted household duties

☐ Interferes with ability to participate in hobbies or other desired activities

☐ Other_____

What have you done that aggravates the problem and/or what have you failed to do that could have helped alleviate it?

_____

If your problem was left untreated for five years, how do you think it would affect you?

_____

Are you committed to getting rid of, not only your symptom(s), but what caused them, even if it requires a change in your lifestyle? ☐ Yes ☐ No

If no, why not?_____

_____