VOITENKO WELLNESS
CHIROPRACTIC NUTRITION

WELCOME
INTAKE FORM

1101 Bryan Avenue - Ste. B
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) _____

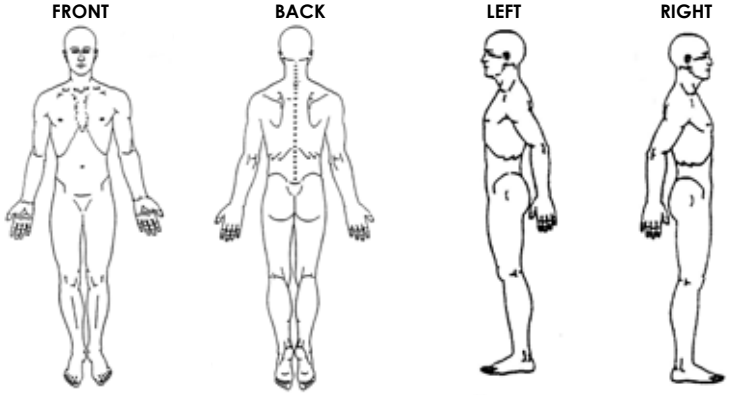
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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
CHIROPRACTIC & NUTRITION

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)

VOITENKO WELLNESS
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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?_____

_____

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Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI (continued)				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours eating after	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive loss hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

VOITENKO WELLNESS
CHIROPRACTIC NUTRITION

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risk associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

_____ _____

Patient (or Legal Guardian) Signature **Witness Signature**

_____ _____

Patient Name (print) **Witness Name (print)**

PRIOR CHIROPRACTIC TREATMENT INFORMATION

Name of Chiropractor: _____ Location (city): _____

When was your last treatment? _____ Have you had x-rays? _____

VOITENKO WELLNESS
CHIROPRACTIC NUTRITION

REQUEST FOR RELEASE OF RECORDS

Patient: _____ Date of Birth:_____

SSN: XXX-XX-_____ _____ _____ _____ Medical Record Number:_____

From DOCTOR(s) or HOSPITAL(s):

❑_____ fax:_____ _____

❑_____ fax:_____ _____

❑_____ fax:_____ _____

❑_____ fax:_____ _____

Effectively immediately, I hereby authorize and request you to release by mail or fax to:

Voitenko Wellness
1101 Bryan Avenue - Ste. B
Tustin, CA 92780

Office: 714-730-2225 Fax: 714-730-2223

❑ X-rays ❑ History ❑ Records ❑ Diagnosis ❑ Treatment ❑ Reports ❑ Billing

The medical records requested are only to be used for medical care. They will not be released to another party without specific written authorization. A photo-copy or facsimile of this request shall be as valid as the original and remain in effect for 12 months from the date of signature below. I may revoke this authorization in writing effective at any time. My next appointment is _____. Thank you for your cooperation and rapid response.

According to section 123110 of the California Health and Safety Code, these records/films must be provided within 15 days of receipt of this notice.

Signed:_____ Date:_____

PROHIBITION OF RE-DISCLOSURE and CONFIDENTIALITY NOTE

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you making any further disclosure without the specific written consent of the persons to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient for this purpose.

The information released is intended only for the use of the individual(s) or entity(s) listed above and is confidential and legally privileged.

VOITENKO WELLNESS
CHIROPRACTIC NUTRITION

HIPAA REQUIRED FORM

Patient consent to the use and disclosure of private health information for treatment. payment or healthcare operations.

I _____, understand that as a part of my healthcare, Dr. Amber Voitenko Chiropractic Offices originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A means by which a third party payer can verify that services billed were provided.

Should it become necessary to disclose my protected information to another health provider or 3rd party payer for the above purposes, I consent to such disclosure for these permitted uses, including disclosures via fax.

In addition, we may post your name on our "referral thank you" board, quarterly newsletter other printed material.

Patient Signature _____ Date _____

THIS WILL BE FILED IN YOUR MEDICAL CHART

Voitenko Wellness
11101 Bryan Avenue - Ste. B, Tustin, CA 92780 Office: 714-730-2225 Fax: 714-730-2223