Date_______________

Last name______________________________ First_________________________MI______

Address_____________________________________City____________State______Zip______

Sex: Male Female S.S.#:_______________________DOB________/_________/________

Cell Phone: (______)_____________________ Work Phone: (______)_______________

E-Mail Address:____

Driver's License/ CA ID #:_________________Referred by:_________________________

Date of injury:__________/___________/_____________

Do you speak, read, write & comprehend English? ☐ YES ☐ NO

Interpreter's name:________________________________

Attorney Name:____________________________Attorney Phone:(______)________________

Attorney Address:____

Insurance Carrier:_________________________Claim/Policy#:___________________________

Insurance Address:____

Contact Person:___________________________ Phone: (______)______________________

PRESENT EMPLOYMENT STATUS

Are you currently working? ☐ Yes ☐ No

Disabled since:________/_________/_________

Unemployment, seeking employment- Last date worked:_________/_________/_________

Current Employer:___________________________________ ☐ Full time ☐ Part time

Current job title and duties:____

☐ Working full unrestricted duty

☐ Working light/modified duty- Please describe:______________________________________

____

Please describe in detail how the injury occurred:______________________________________

____

____

What were you doing at the time of the accident?

____

What direction did the impact come from?

____

What speed were you traveling? (If known)

____

What speed was the other driver traveling? (If known)

____

Where were you looking at the time? Circle one answer.

Ahead
Down
To the right
To the left
Over the shoulder

What happened after the impact? Circle all that apply.

Felt disoriented
Felt discomfort
Felt immediate pain
Felt tightness
Lost consciousness
Was frightened
Was stunned
Went to hospital

Have your daily activities been affected?

____

____

What body parts are injured?____

Did anyone see the accident?____

Was the accident reported?____

When did you first seek treatment?____

Where did you first seek treatment?____

What kind of treatment did you receive? (X-rays, physical therapy, medications, surgery, ect.)__

____

How long did you receive this treatment?____

Have you had any of the following tests since your injury?

MRI Scan: ☐Back ☐Neck ☐Shoulder ☐Knee Other:__________Date(s):___________

CT Scan: ☐Back ☐Neck Other:_________________________Date(s):________________

EMG/NCV: ☐Neck/Arm ☐Lower back/Legs Other:_____________Date(s):_______________

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Number of children:______________ Age(s):____________________
Do you smoke? ☐ No ☐ Yes ________ #of packs a day # of years__________________
Do you drink alcohol? ☐ None ☐ Occasionally ☐ Often ☐ Heavy

PAST MEDICAL HISTORY

IMPORTANT: YOU MUST INFORM US OF ALL INJURIES YOU HAVE SUSTAINED, BOTH BEFORE AND AFTER THE CURRENT INJURY. FALURE TO INFORM US OF THIS INFORMATION COULD NEGATIVLY AFFECT THE VALIDITY OF OUR REPORT AND COULD HAVE NEGATIVE CONSEQUENCES FOR YOUR CASE.

Previous accidents and/or injuries:____

Fractures or surgeries (please give dates):____

Medical conditions (hypertension, diabetes, rheumatoid arthritis, ect.):____________________

____

Current medications (please give name, dosage and frequency):__________________________

____

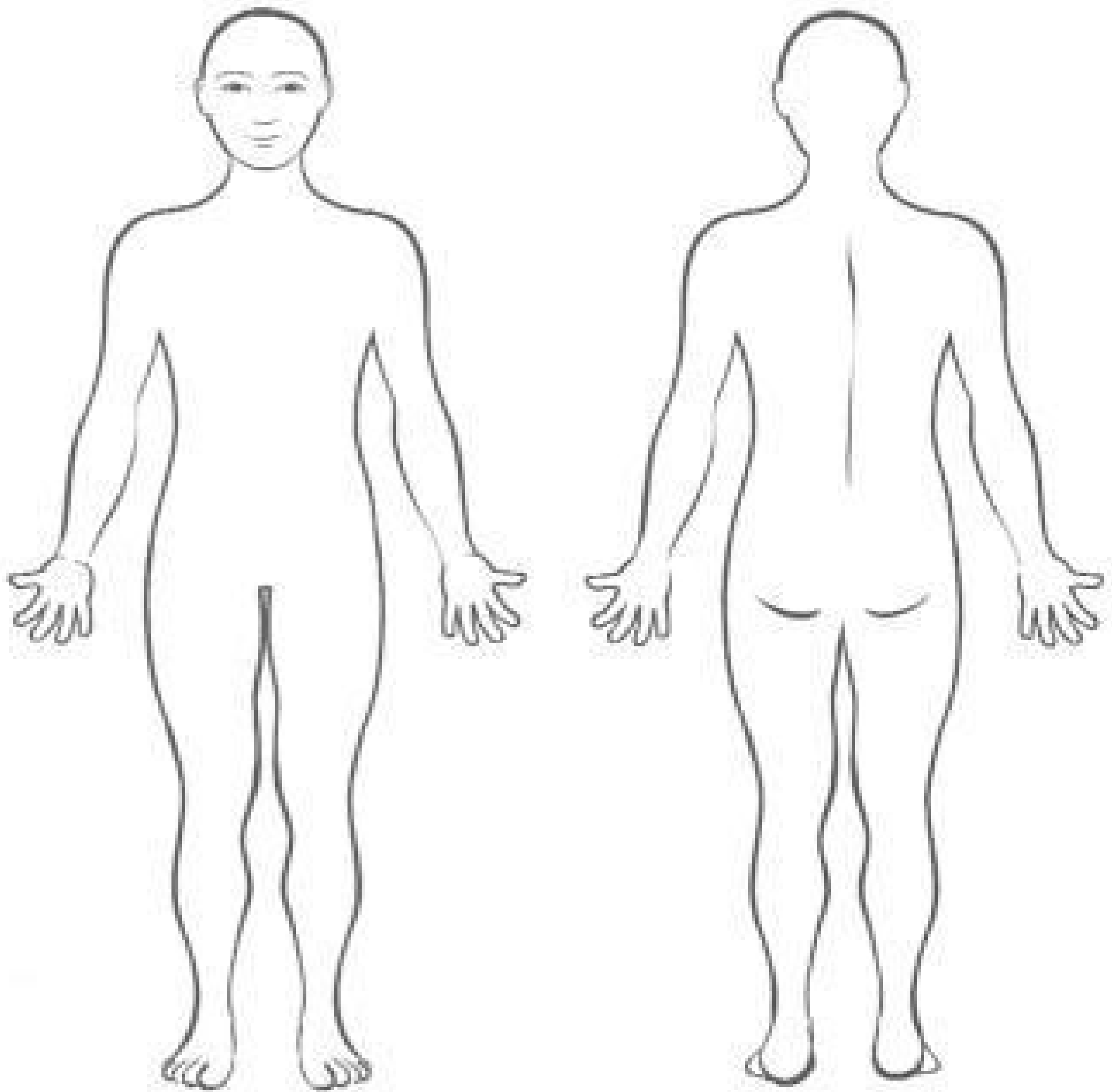
PRESENT COMPLAINTS

Is the pain worse during any of the following?

☐Lifting ☐Standing ☐Bending ☐Squatting ☐Kneeling ☐Walking

☐Sitting ☐Driving ☐Morning ☐Midday ☐Night

	Symptoms		Symptoms		Symptoms
	Headache		Shortness of breath		Chest pain
	Neck Pain		Fatigue		Knee pain
	Stiff neck		Ankle pain		Shoulder pain
	Dizziness		Loss of memory		Wrist pain
	Head seems too heavy		Ears ring		Hand pain
	Numbness to fingers		Loss of Balance		Sleeping problems
	Numbness to toes		Disoriention		Elbow pain
	Pins & needles in arm		Blurred vision		Uncontrollable bladder/bowel
	Pins & needles in legs		Back Pain		Abdominal pain
	Foot pain		Groin pain		Other:



Mark with an “X” the area(s) on the figures where you feel pain. If your pain radiates into an extremity, please indicate that on the figures.

Have you had spinal: X-RAYS, MRI, CT SCAN? ☐ NO ☐ YES, Date(s) Taken:____________________

What areas where taken?____

Please check all of the following that apply to you: ☐ NONE APPLY

NO	YES	NO	YES
☐	☐History or Recent Infection	☐	☐ Prostate problems
☐	☐Recent Fever	☐	☐ Frequent Urination
☐	☐HIV/AIDS	☐	☐ Pregnancy, # of births______
☐	☐ Diabetes	☐	☐ Abnormal Weight Gain or Loss
☐	☐ Corticosteroid use	☐	☐ Epilepsy/ Seizures
☐	☐Birth Control Pills	☐	☐ Visual Disturbances
☐	☐ High Blood Pressure	☐	☐ History of Low/Mild Back Pain
☐	☐ Stroke(date)	☐	☐ History of Neck Pain
☐	☐ Dizziness/Fainting	☐	☐ Arthritis
☐	☐ Numbness in Groin/Buttocks	☐	☐ History of Alcohol Use
☐	☐ Urinary Retention	☐	☐ History of Tobacco Use
☐	☐ Aortic Aneurysm	☐	☐ Surgeries/Medications:
☐	☐ Cancer/Tumor	☐	☐ _________________________________
☐	☐ Osteoporosis		_________________________________
☐	☐ Recent Trauma		_________________________________

FAMILY HISTORY:☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐Cardiovascular Problems/Stroke

I certify the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changed in my health condition or health plan coverage in the future.

Patient Signature:______________________________________ Date:_________________________

INFORMED CONSENT FOR CHIROPRACTIC CARE

To the patient (or their parent, legal guardian, court appointed conservator, or agent): Please read this entire form prior to signing it. It is important that you understand the information contained in this form. Please ask any questions prior to signing this form if you are unclear about anything in this form.

Chiropractic Adjustments -

The primary treatment rendered by the Doctor of Chiropractic to you will be chiropractic adjustments, which are purposely intentioned movements of bones with the desired effect being to remove interference to nerves, which then allows your body to use its innate ability to heal itself. Chiropractic adjustments also have the desirable effect enabling muscles, tendons, and ligaments to properly function and heal, and also allows blood flow to properly occur. Chiropractic adjustments can be made by either the use of hands or mechanical instruments to any bone or joint in the body including both spinal and extremity bones. You may or may not hear an audible sound, which is just air being released from the joint space as bones are moved into their proper positions.

Other Procedures -

There are several other procedures used by Doctors of Chiropractic that may be used on you. A physical examination will be performed to obtain a baseline level of functioning as well to partially determine an appropriate course of treatment and associated recommendations. The physical examination may include posture checks, range of motion testing, muscle strength testing, various neurological and orthopedic testing, and other testing. Radiology is the use of x-rays on the human body and is used to gain an inside perspective of the human body that cannot be obtained from a physical examination. Treatment may include chiropractic adjustments, physio therapy (such as ultrasound, interferential therapy, massage therapy, exercise recommendations, etc.). Additionally, there may referrals to other doctors as necessary, and their treatment should involve the same informed consent with disclosure of risks and benefits as is being done here. For example, there can be permanent pain as a side effect of surgery as one possible consequence of that procedure.

Potential Benefits of Chiropractic and Associated Care -

The vast majority of chiropractic patients tend to achieve good to excellent improvement in their physical conditions with chiropractic care. Improvement can be measured in many different ways, including reduction in pain, increased range of motion, less stiffness, increased athletic performance, and other ways. It must be remembered that different people get different results, different people have different pre-existing conditions, and are of different ages and occupations (with different types of physical stress). Your situation is unique, and no guarantees are given. You will have to determine what results you get for yourself and report them to your Doctor of Chiropractic.

Material risks Inherent with Chiropractic Adjustments and Other Treatment -

As with any healthcare procedure, there are certain complications which may arise when chiropractic adjustments and other care/procedures are performed. These complications include but are not limited to fractures of bones, disc injuries, dislocations, muscle strains, cervical myelopathy, strokes, radiation exposure, costovertebral strains and separations, and burns. Some patients feel some stiffness and/or soreness following the first few days of treatment. The physical exam can temporarily worsen symptoms, but is a necessary part of chiropractic care. The Doctor of Chiropractic will make every reasonable effort during the examination to screen for contraindications to care, but remember it is your responsibility to inform the Doctor of Chiropractic of any conditions that would not otherwise come to their attention.

Probability of Risks Occurring -

Fractures are rare occurrences and generally result from some underlying weakness of bone. Even though a competent history, examination (which may include radiography) will be performed, it is still possible for some weaknesses of bone to be undetected. Extremely rare are strokes from vertebral artery dissection which also occur in about one person

in 133,000 in general (not related to chiropractic), but are estimated to occur in between one in one million and one in five million cervical adjustments. Although discs are generally helped with chiropractic care, they can be worsened even to the point of requiring surgical care (although this rarely occurs). Physio therapy can sometimes burn skin by irritating it, although this is unlikely to occur.

A perspective on the risks of chiropractic care as compared to medical care can been seen by the money paid by different doctors for a $1,000,000 malpractice liability policy. The following annual premiums listed are close approximations, although not exact. A general medical doctor pays about $20,000 per year, an internal medicine specialist pays about $50,000 per year, and medical specialists such as surgeons, cardiologists, and obstetrics and gynecologists (OBGYN) pay about $150,000 per year for a $1,000,000 malpractice liability policy. In stark contrast to medical doctors who patients encounter significant more risk that Doctors of Chiropractic, Doctors of Chiropractic in California pay about $3,000 per year. Also, it has been reported that about 187,000 deaths occur every year from medical malpractice, but that the number for chiropractic is typically zero per year.

Consequences of Not Obtaining Chiropractic Care -

Not obtaining chiropractic care will have the effect of not obtaining its benefits such as having your body function at its best ability, reducing pain, peak athletic performance, etc. Not obtaining chiropractic care may allow formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult, requiring more time (and money), and less effective when chiropractic care is obtained later in time. Not obtaining chiropractic care following trauma such as whiplash or other effects of automobile accidents will cause injured muscles, tendons, and ligaments to heal improperly and be significantly weaker and more prone to reinjury as compared to receiving proper chiropractic care.

Alternatives to Chiropractic Care -

Other treatment options for your condition may include rest, acupuncture, physical therapy, medical care, medications (both over the counter and prescribed), hospitalization, and surgery, and others. If you choose to use other treatment options, you should discuss the risks and benefits with your medical doctor or other provider.

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND UNDERSTAND THIS FORM. UPON DOING SO, PLEASE COMPLETE THE INFORMATION AND SIGN THIS FORM.

______________________________________ ______________________________

Signature of patient, guardian, conservator, or agent — Date

____

Patients Printed Name

PLEASE **DO NOT** SIGN THIS FORM UNTIL AFTER YOUR TREATMENT PLAN HAS BEEN REVIEWED WITH YOU BY YOUR DOCTOR

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	DOCTORS COMMENTS
GENERAL		
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	☐	
BONE WEAKNESS		
Have you been diagnosed with osteoporosis?	☐	
Do you take corticosteroids (e.g. prednisone)?	☐	
Have you ever been diagnosed with a compression fracture(s) of the spine?	☐	
Have you ever been diagnosed with cancer?	☐	
Do you have any metal implants?	☐	
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	☐	
If yes, about how much do you take daily?	☐	
Do you take warfarin (coumadin); heparin, or other “blood thinners”?	☐	
Have you ever been diagnosed with any of the following disorders/diseases?		
• Rheumatoid Arthritis	☐	
• Reiter’s syndrome, anchylosing spondylitis, or psoriatic arthritis	☐	
• Giant cell arteritis (temporal arteritis)	☐	
• Osteogenesis imperfecta	☐	
• Ligamentous hypermobility (Marfan’s disease, Ehlers-Danlos syndrome)	☐	
• Medical cystic necrosis (cystic niucold degeneration)	☐	
• Bechet’s disease	☐	
• Fibromuscular dysplasia	☐	
Have you ever become dizzy or lost consciousness when turning your head?	☐	
SPINAL COMPROMISE OR INSTABILITY		
Have you had spinal surgery?	☐	
If yes, when? _____________		
Have you been diagnosed with spinal stenosis?	☐	
Have you been diagnosed with spondylolisthesis?	☐	
Have you had any of the following problems?		
• Sudden weakness in the arms or legs?	☐	
• Numbness in the genital area?	☐	
• Recent inability to urinate or lack of control when urinating?	☐	

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me ad suggested alternative when those risks exist. I understand the purpose of my care and have been explained the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

Patient [or PARENT/GUARDIANS SIGNATURE____ DATE_____________________

Doctors Signature ____ DATE_____________________

Notice of Privacy Practices

ACKNOWLEDGMENT OF RECEIPT: by signing this form, you acknowledge receipt of the notice of privacy practices of VOITENKO WELLNESS.

Our notice of privacy practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our privacy officer at (714) 730-2225

I acknowledge receipt of the notice of privacy practices of VOITENKO WELLNESS.

Signature: ____ Date: _______________________________

Print Name: ____

***************************FOR OFFICE USE ONLY**************************************

INABILITY TO OBTAIN ACKNOWLEDGEMENT
To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why the acknowledgement was not obtained:

Signature of provider representative: ________________________________ Date:_____________________

( ) Individual refused to sign

( ) Communication barriers prohibited the acknowledgment

( ) An emergency situation prevented us from obtaining acknowledgement

( ) other (please specify)____

____

Voitenko Wellness & Chiropractic Services
1101 BRYAN AVE, STE B | TUSTIN, CA 92780
info@voitenkowellness.com
PH: 714-730-2225 FAX: 714-730-2223

RELEASE OF MEDICAL INFORMATION

TO:_______________________________________

____

____ DATE: __________________________

You are hereby authorized and requested to furnish any and all medical information, history, records, diagnosis, reports and/or x-rays/MRIs in your possession concerning the undersigned.

________________________________ ______________________________________
PATIENTS NAME PATIENTS SIGNATURE

________________________________ ______________________________________
SIGNATURE OF PARENT OR GUARDIAN REQUESTING PHYSICIAN

PLEASE SIGN BELOW AND RETURN TO OUR OFFICE IF YOU DO NOT HAVE RECORDS IN YOUR POSSESION.

________________________________ ______________________________ ____________
PATIENT SIGNTURE PRINT NAME DATE

ASSIGNMENT OF BENEFITS

I request that payment under my insurance program be made to Voitenko Wellness for any services furnished to me. I authorize Voitenko Wellness to release any information needed or this claim to the necessary carriers or their intermediates, I also request that a copy of this information be used in place of the original.

STATEMENT OF CONFIDENTIALITY

I authorize the release of necessary medical information to Voitenko Wellness for the purpose of processing this or any related insurance claims. I also give Voitenko Wellness the authority to make available any requested documents contained in my file to myself and/or other health providers involved in the treatment of my condition.

AGREEMENT

I acknowledge that I am fully responsible for the payment of any services provided to me by Voitenko Wellness. I understand that if Voitenko Wellness submits a claim for billed charges to my insurance plan(s) on my behalf, I am not relieved of my financial responsibility for payment: in the event that the insurance plan or any third-party payor does not pay the entire billed amount, I agree to pay any remaining balances except as restricted by specific Medicare and Medicaid reimbursement policies.

By signing below, I acknowledge and accept the terms and conditions above.

Patient Name:___________________________________

Patient, or legal Representative, signature:__________________________________

Date:____

NOTICE TO MY ATTORNEY OF DOCTOR LIEN

I hereby authorize Voitenko Wellness to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc of me regarding the accident on or about ____________________ for which you have been retained.

I understand that all bills occurred by me, at Voitenko Wellness's office, are my responsibility to pay and I will either pay them in full at the time of service or make payment arrangements with Voitenko Wellness. I also understand that, unlike my attorney, Voitenko Wellness does not work on a contingency fee and I must pay for services at the time of rendering of them and that this lien is only to protect their interests in case there is a balance owing when my case is resolved.

I irrevocably instruct my attorney to withhold from my settlement or judgment any amount that, at that time, is owed to Voitenko Wellness for my health care in connection with his accident and pay it directly and promptly to Voitenko Wellness at:

Voitenko Wellness
1101 Bryan Ave, Ste B
Tustin, CA 92780

I am granting Voitenko Wellness an irrevocable lien on the proceeds of my legal case and it is my intent that this lien shall be binding on my present attorney and/or any subsequent attorney, which wither I might hire or to whom my present attorney may assign this case.

______________________________ ______________________________ ____________________

PATIENT NAME PATIENT/GUARDIAN SIGNATURE DATE

I, the attorney on record for the above-named signatory, regarding the accident in question, hereby agree to abide by the terms of this lien.

______________________________ _______________________________ ____________________

ATTORNEY NAME ATTORNEY SIGNATURE DATE