



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/Case Manager Email: \_\_\_\_\_

Personal Car Insurance: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Claim/Policy#: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Third Party Car Insurance: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Claim/Policy#: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

**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?

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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.) \_\_\_\_\_

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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. FAILURE TO INFORM US OF THIS INFORMATION COULD NEGATIVELY 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.): \_\_\_\_\_

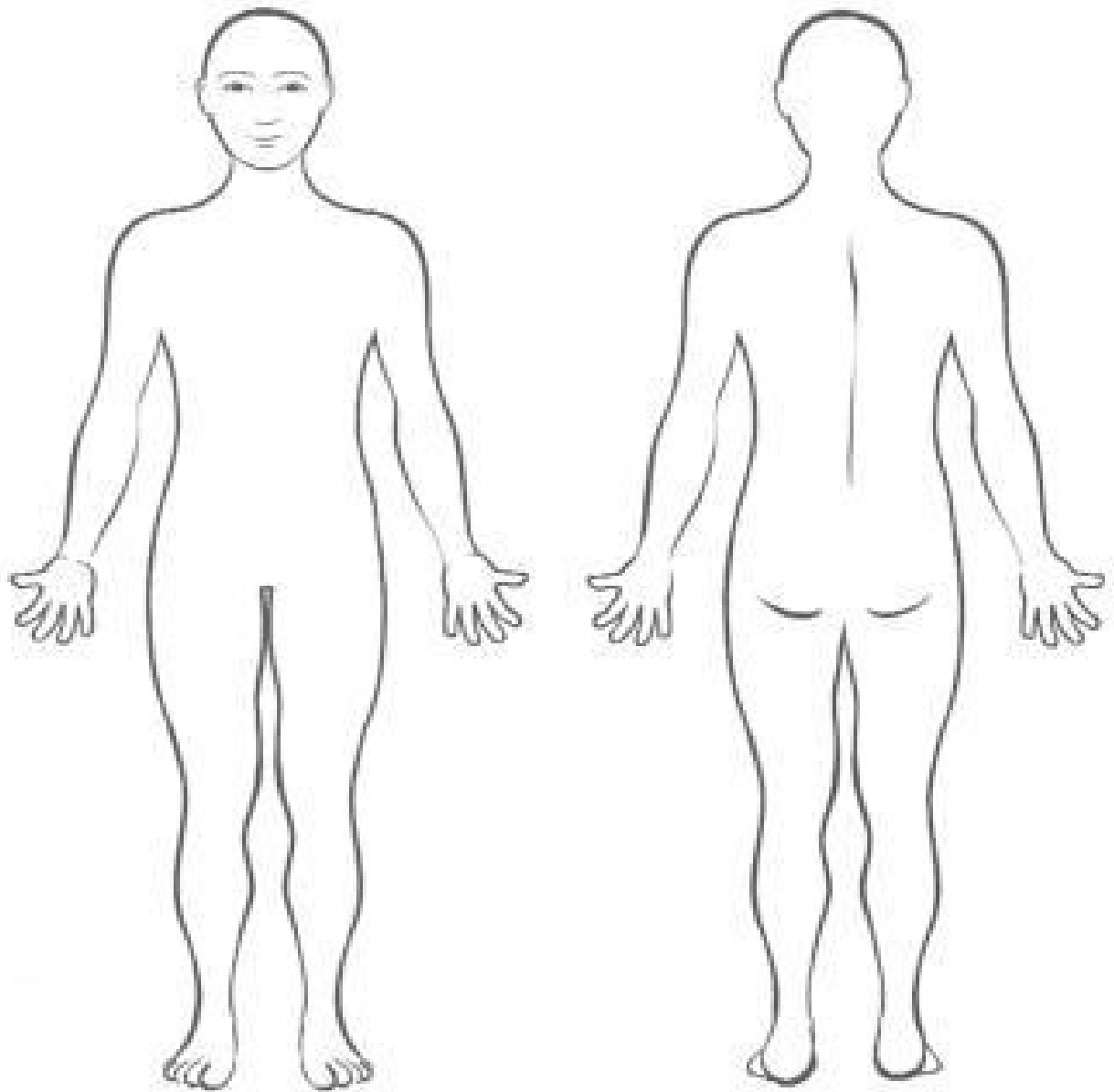
Current medications (please give name, dosage and frequency): \_\_\_\_\_

**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	Disorientation	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 were taken? \_\_\_\_\_

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

NO	YES	NO	YES
<input type="checkbox"/>	<input type="checkbox"/> History or Recent Infection	<input type="checkbox"/>	<input type="checkbox"/> Prostate problems
<input type="checkbox"/>	<input type="checkbox"/> Recent Fever	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy, # of births _____
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain or Loss
<input type="checkbox"/>	<input type="checkbox"/> Corticosteroid use	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy/ Seizures
<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> History of Low/Mild Back Pain
<input type="checkbox"/>	<input type="checkbox"/> Stroke(date)	<input type="checkbox"/>	<input type="checkbox"/> History of Neck Pain
<input type="checkbox"/>	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/> Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Numbness in Groin/Buttocks	<input type="checkbox"/>	<input type="checkbox"/> History of Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/> Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/> History of Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/> Surgeries/Medications:
<input type="checkbox"/>	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis		_____
<input type="checkbox"/>	<input type="checkbox"/> 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 be 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
<b>GENERAL</b>		
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	<input type="checkbox"/>	
<b>BONE WEAKNESS</b>		
Have you been diagnosed with osteoporosis?	<input type="checkbox"/>	
Do you take corticosteroids (e.g. prednisone)?	<input type="checkbox"/>	
Have you ever been diagnosed with a compression fracture(s) of the spine?	<input type="checkbox"/>	
Have you ever been diagnosed with cancer?	<input type="checkbox"/>	
Do you have any metal implants?	<input type="checkbox"/>	
<b>VASCULAR WEAKNESS</b>		
Do you take aspirin or other pain medication on a regular basis?	<input type="checkbox"/>	
If yes, about how much do you take daily?	<input type="checkbox"/>	
Do you take warfarin (coumadin); heparin, or other "blood thinners"?	<input type="checkbox"/>	
Have you ever been diagnosed with any of the following disorders/diseases?		
• Rheumatoid Arthritis	<input type="checkbox"/>	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	<input type="checkbox"/>	
• Giant cell arteritis (temporal arteritis)	<input type="checkbox"/>	
• Osteogenesis imperfecta	<input type="checkbox"/>	
• Ligamentous hypermobility (Marfan's disease, Ehlers-Danlos syndrome)	<input type="checkbox"/>	
• Medical cystic necrosis (cystic niucold degeneration)	<input type="checkbox"/>	
• Bechet's disease	<input type="checkbox"/>	
• Fibromuscular dysplasia	<input type="checkbox"/>	
Have you ever become dizzy or lost consciousness when turning your head?	<input type="checkbox"/>	
<b>SPINAL COMPROMISE OR INSTABILITY</b>		
Have you had spinal surgery?	<input type="checkbox"/>	
If yes, when? _____		
Have you been diagnosed with spinal stenosis?	<input type="checkbox"/>	
Have you been diagnosed with spondylolisthesis?	<input type="checkbox"/>	
Have you had any of the following problems?		
• Sudden weakness in the arms or legs?	<input type="checkbox"/>	
• Numbness in the genital area?	<input type="checkbox"/>	
• Recent inability to urinate or lack of control when urinating?	<input type="checkbox"/>	

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and 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 POSSESSION.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
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