Kristina Wodicka, DC
16 Collyer Avenue
Valley Cottage, NY 10989
littlewaterswellness@gmail.com
www.drwodicka.com
845-535-5299

New Patient Information

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Day/Night Phone # (_____) _____Other Phone # (_____) _____

DOB _____ Age _____ Gender _____

Email Address _____ ☐ Yes! Please send me news & updates via e-mail!

Marital Status M S D W Number of Children: Boys _____ Girls _____

Employer _____ Occupation _____

Address _____ City_____ State _____ Zip_____

Work Phone (_____) _____

Name of Spouse _____ Phone # (_____) _____

Contact in case of Emergency _____ Phone # (_____) _____

How were you referred to our office?

-A friend/relative/coworker/other referred me. Name of person: _____

-Other. Please describe source: _____

PERSONAL HISTORY QUESTIONNAIRE

Chief Complaint

Please describe present complaint fully: _____

_____

_____

_____

Duration of condition? _____

Is the condition you are here for the result of a work related injury? Yes _____ No _____

Is the condition you are here for the result of an automobile collision? Yes _____ No _____

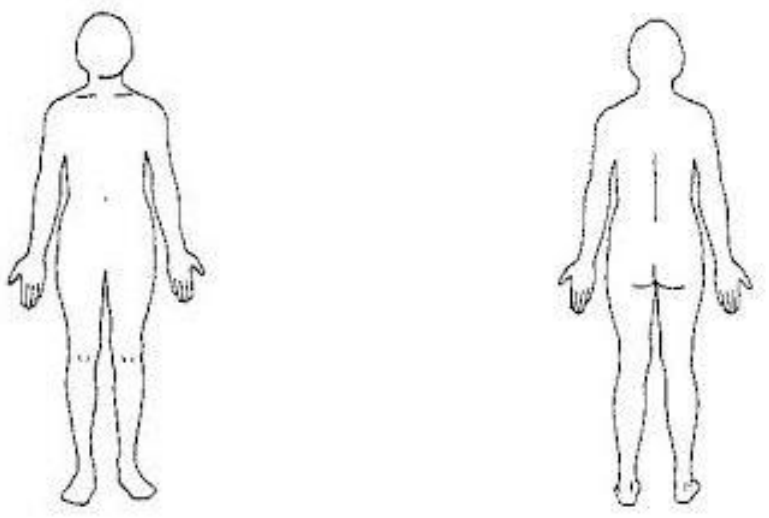
What are your wellness goals? _____

_____

_____

PERSONAL HISTORY QUESTIONNAIRE CONTINUED…

Please circle the areas on the drawings below where the pain/discomfort is.



BELOW FOR DR. WODICKA'S USE ONLY

Still a problem?

Feet: R L _____ YES NO

Toes: _____ YES NO

Ankles: R L _____ YES NO

Lower Leg: R L _____ YES NO

Knees: R L _____ YES NO

Thighs: R L _____ YES NO

Hips: R L _____ YES NO

Tail Bone: _____ YES NO

Lower Back: _____ YES NO

Spine: _____ YES NO

Neck: _____ YES NO

Head: _____ YES NO

Face: _____ YES NO

Shoulders: R L _____ YES NO

Elbows: R L _____ YES NO

Wrist: R L _____ YES NO

Hands: R L _____ YES NO

Fingers _____ YES NO

Internal organs _____

_____

PERSONAL HISTORY QUESTIONNAIRE CONTINUED…

Have you received spinal adjustments and/or neuro emotional technique session from a Doctor of Chiropractic before? _____

When was the date of your last Physical/Chiropractic exam: _____

Physical History

Was your birth:

☐ Drug Induced ☐ "C" Section ☐ Natural

☐ Breech ☐ Forceps or suction ☐ Cord around the neck

☐ Prolonged ☐ Other:_____

Indicate the traumas that apply:

Falls from: ___ crib ___ carriage ___ down or up steps ___ on ice ___ sports

___ knocked unconscious ____ broken bones

___ impacts, falls that may have injured your spine

___ extensive dental or orthodontic work

___ involved in a vehicular collision in a: ___ Automobile ___ Bus ___ Bicycle ___ Train

___ Motorcycle ___ Airplane or others: _____

Have you ever used crutches, walker or cane? ___ Yes ___ No

During the day I: ___ sit ___ stand ___ do deskwork ___ phone work ___ drive

___ do mechanical work ___ heaving lifting ___ computer work

I exercise: ___ daily ___ weekly ___ monthly Describe: _____

Medical Treatment

Have you ever been hospitalized? _____ If yes, please describe what for: _____

_____

Have you had any surgeries (If yes, please specify what for)? _____

_____

Have you had: ___ spinal tap ___ spinal injections ___ physiotherapy ___ neck collar

___ spinal brace ___ traction ___ heel lift ___ x-ray treatments ___ corrective shoes

___ transfusion ___ chemotherapy ___ extensive diagnostic x-rays ___ body part in a cast or immobilized?

Please list any significant medical history with:

Children: _____

Parents: _____

Siblings: _____

Allergies: _____

_____

PERSONAL HISTORY QUESTIONNAIRE CONTINUED…

Chemical History

Please list significant medications that you have taken or are currently taking (include vitamins). List purpose and dates of usage: _____

_____

_____

Did you or do you work with any chemicals, fumes, dust, or smoke? ___ Yes ___ No

Please indicate which of the following you consume:

☐ Alcohol	☐ Eggs	☐ Beef
☐ Coffee	☐ Cooked vegetables	☐ Poultry
☐ Tobacco	☐ Raw vegetables	☐ Fish
☐ Artificial Sweeteners	☐ Fruit	☐ Sea Food
☐ Soda	☐ Whole Grains	☐ Diet food
☐ Weight control diet	☐ Dairy (milk products)	☐ Fasting
☐ Refined sugar	☐ Fried foods	☐ Organic foods

The type of diet I usually follow is classified as: _____

Please list any significant chemical history with:

Children: _____

Parents: _____

Siblings: _____

Emotional History –birth stress

My birth was: ___ at home ___ in a birthing center ___ in a hospital ___ other

Were you: ___ incubated ___ isolated after birth ___ bottle fed formula ___ bottle fed mother's milk

___ nursed (if so, for how long? _____)

Indicate the stressed that apply (past or present):

☐ Childhood stress	☐ School stress	☐ Family stress
☐ Personal relationships	☐ Stress and sickness	☐ Work related
☐ Stress of commuting	☐ Loss of loved one	☐ Moving
☐ Change of vocation	☐ Change of life style	☐ Abuse of any type

Is there anything else you may wish to share which may help to better understand you and why you have chosen to come here for your care? _____

_____

_____

_____

TERMS OF ACCEPTANCE

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine, and for the patient to understand what to expect from chiropractic care. It is the chiropractic premise that proper spinal alignment allows normal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. In this way, chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic procedures often depends on environment, underlying causes, and the physical and spinal conditions of each individual patient. It is important that the patient understands what to expect from your chiropractic care. Due to the complexities of nature, and the many variables (both known and unknown) that can affect the patient's response, no doctor can promise specific results. The Doctor of Chiropractic provides a specialized, unique, non-duplicating health service. The Doctor of Chiropractic is licensed in a special are of practice and is available to work with other types of providers in your health care regime.

When a patient seeks Chiropractic Health Care and we accept the patient for such care, it is essential for both to be working toward the same goals and objectives.
The goal of Chiropractic in this office is to correct subluxations and improve the biomechanics of the muscles and joints of the spine and extremities, so as to restore a more optimal state of health and balance the body. It is important that each patient understand both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of force to facilitate the body's correction of vertebral or extremity subluxations, or cranial faults using manual thrust, light touch, an adjustor or activator methods.
Health: A state of optimal physical, mental, and emotional well-being, not merely the absence of disease or infirmity.
Vertebral subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column, which cases alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's inhale ability to express its maximum potential.

Our Practice Objective is to eliminate major and minor interferences to the expression of the body's innate wisdom. Our method is to correct vertebral and extremity subluxation, cranial faults and when applicable, add appropriate exercise and/or soft tissue to work to support the chiropractic adjustment.

NAET

1. Allergy treatment (NAET) is not a medical diagnostic procedure and therefore does not diagnose disease. Rather allergy treatment gives the practitioner an indication as to the substance(s) to which the patient may have sensitivity.
2. The premise behind NAET is to desensitize a patient to a substance(s) using acupuncture/acupressure, nutritional and kinesioglogical principals so that the patient may not experience hypersensitive symptoms when they have future contact with the item.
3. Patient is advised to continue with all their medications and other treatment modalities as they have been prescribed by their Physician.
4. Please note that the treatment may not work the first time and you may still have a sensitivity reaction. If needed more than one treatment, it is still considered an office visit and charged accordingly.
5. During the clearing period of 25 hours after treatment, if a life-threatening reaction from the allergen happens, you need to seek emergency help immediately from a physician qualified in emergency treatments. You should follow their advice for treatment.
6. Currently this Allergy Relief Technique is not considered to be validated through published research data and is not approved by Insurance for payment of service.
7. Dr. Wodicka reserves the right to refuse treatments to anyone.

NET

NET is a mind-body technique that uses a methodology of finding and removing neurological imbalances related to the physiology of unresolved stress. NET is a tool that can help improve many behavioral and physical conditions. NET is based on the physiological foundations of stress-related responses. As discovered in the late 1970s, emotional responses are composed of neuropeptides (amino acid chains) and their receptors, which lie on neurons and other cells of remote tissues in the body. The neuropeptides are ejected from the neuron and carry the encoded "information" to other sites within the body. These neuropeptides are in a category of neurochemicals known as Information Substances (IS). ISs are released at times of stress-related arousal and become attached to remotely-positioned neuroreceptors. Significantly, this process also happens when a person recalls to memory an event in which a stress originally occurred. This is a key factor in the NET treatment. Thus, the physiological status of the body is emotionally replicating a similar physiological state that was found in the original conditioning event by the process of remembering.

I, _____, have read and fully understand all the objectives pertaining to chiropractic care, NAET, and NET. All questions regarding the doctor's objectives regarding my care in this office have been answered to my complete satisfaction.
I therefore accept care on this basis.

_____ _____

Signature Date

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including, but not limited to various modes of manual therapy, muscle testing, and therapeutic instruments on me (or on the patient named below for whom I am legally responsible) by Dr. Wodicka.

By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures whether he/she is suffering from pathological conditions (latent or otherwise), illnesses, injuries, or deformities which would otherwise not come to the attention of the doctor.

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;
b. The nature of the treatment;
c. The risks and benefits of that treatment
d. Any alternatives to that treatment

1. I have had the opportunity to ask questions and receive answers regarding the treatment. I understand that results are not guaranteed.
2. I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation.
3. I intend this consent to apply to all my present and future care with Dr. Kristina Wodicka.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature (or Parent or Legal Guardian) Witness Signature

CONSENT TO TREAT

I, _____, hereby consent, authorize and request Dr. Kristina Wodicka to administer the treatment deemed advisable and necessary to my (my responsibilities) condition in accordance with his/her best expertise. I agree to hold him/her free and harmless from any claims, suits for damages or complications which may result from further treatment.

PAYMENT DUE AT THE TIME OF SERVICE

I am financially liable for the payment of services rendered by Dr. Wodicka and I understand that payment needs to be made prior to treatment. I do understand that Dr. Wodicka currently does not accept Insurance Payments for chiropractic care, NAET, and NET.

_____ _____

Signature Date

Consent to treat minor

I_____ hereby authorize Dr. Kristina Wodicka DC.P.C. to administer

(Parent of legal guardian)

treatment as deemed necessary to _____.

(Minor Name)

_____

Parents or Legal Guardian's Signature

Date _____