WELCOME TO BOMONTI CHIROPRACTIC

Please answer all the following that apply to you.

PLEASE PRINT YOUR NAME_____ TODAY'S DATE __/__/____

WHO REFERRED YOU TO OUR OFFICE?_____

HOW CAN WE HELP YOU, WHAT IS YOUR HEALTH CONCERN?_____

HOW LONG HAVE YOU HAD THIS PROBLEM, THIS TIME?_____ ___HAVE YOU HAD IT BEFORE?_____

WHAT CAUSED YOUR PROBLEM THIS TIME? _____

HOW LONG, ON & OFF HAVE YOU HAD THIS PROBLEM?_____ WHEN WAS THE LAST EPISODE?_____

WHAT WAS THE ORIGINAL CAUSE OF YOUR PROBLEM?_____

WHAT HAVE YOU DONE FOR THIS CONDITION THIS TIME? (INCLUDE DR'S SEEN, PRESCRIPTION & OTC MEDICATIONS, THERAPISTS, HOME CARE SUCH AS ICE, HEAT, EXERCISE, STRETCHING, ETC)_____

_____

WHAT LEVEL OF CARE DO YOU WANT? EMERGENCY_____ BACK TO WHERE I WAS _____ THE BEST POSSIBLE____

DO YOU DO ANY AEROBIC EXERCISE?_____ WHAT?_____ HOW OFTEN?_____

HOW OFTEN DO YOU DO STRETCHING EXERCISE/WEEK?_____ HOW MUCH WATER DO YOU DRINK?_____

HOW MUCH MILK DO YOU DRINK?_____ HOW MUCH CAFFINE DO YOU HAVE DAILY (POP, COFFEE)_____CUPS

DO YOU DRINK ALCOHOLIC BEVERAGES? NEVER – RARE – SOCIAL – DAILY – QUIT (WHEN_____)

DO YOU SMOKE? Y-N # OF PKS____ QUIT? WHEN_____ HOW MANY HOURS DO YOU SLEEP NIGHTLY?_____

DO YOU WAKE RESTED?_____ DO YOU SLEEP ON YOUR SIDE, BACK OR STOMACHE?_____

HOW OFTEN DO YOU WAKE AT NIGHT FOR ANY REASON?_____ DOES SOMEONE SAY YOU SNORE?_____

DO ANY FOODS UPSET YOU AND WHICH ONES?_____

DO YOU HAVE ANY BOWEL OR URINE PROBLEMS? _____ WHAT?_____

DO YOU HAVE TO URINATE AT NIGHT? _____ HOW OFTEN?_____ HAVE THERE BEEN ANY CHANGES IN YOUR BOWEL OR URINE HABITS RECENTLY?_____ WHEN_____ WHAT?_____

LIST ANY PROBLEMS WITH YOUR PERIODS OR MENOPAUSE _____

FAMILY HISTORY OF CANCER, HEART DISEASE, DIABETES, OTHER Y – N WHAT?_____

_____ WHO _____

(EVERYONE) WHAT VITAMINS, MINERALS, HERBS, HOMEOPATHIC REMEDIES DO YOU TAKE?_____

_____

WHAT DOES THIS PRESENT CONDITION PREVENT YOU FROM DOING?_____

WHAT DO YOU LOOK FORWARD TO BEING ABLE TO DO? SHORT TERM_____

LONG TERM_____

WHAT DO YOU DO FOR FUN AND/OR RELAXATION?_____

PLEASE LIST ANY OTHER CONCERNS OR PROBLEMS YOU THINK I SHOULD KNOW ABOUT._____

_____

PLEASE SIGN YOUR NAME._____ TODAYS DATE (AGAIN)____/___/_____

PLEASE TURN THIS FORM OVER AND COMPLETE THE OTHER SIDE

DATE:_____

CONFIDENTIAL PATIENT INFORMATION

NAME:_____HOME PHONE:_____
ADDRESS:_____CITY:_____ZIP CODE:_____
AGE: _____BIRTHDATE:___/___/___ MARITIAL: *M S W D C SEP* HOW MANY CHILDREN:_____
OCCUPATION:_____EMPLOYER:_____
ADDRESS:_____ CITY_____ STATE_____
OFFICE PHONE:_____ CELL PHONE #_____
E-MAIL ADDRESS _____ Authorized to email Yes ___ NO ___
(used for office newsletters, forms, and reminders for appointments, will not release or sell)
SPOUSE NAME:_____OCCUPATION:_____
WHO REFERRED YOU TO OUR OFFICE?:_____

*****PLACE AN "X" BY ANY OF THE CONDITIONS BELOW YOU MAY HAVE OR HAVE HAD*****

SCARLET FEVER	_____	*HEART DISEASE*	_____	*LUNG DISEASE*	_____
RHEUMATIC FEVER	_____	*DIABETES*	_____	*DIFFICULT BREATHING*	_____
TYPHOID	_____	*KIDNEY DISEASE*	_____	*ASTHMA*	_____
DYSENTERY	_____	*LIVER DISEASE*	_____	*ALLERGIES*	_____
TUBERCULOSIS	_____	*NERVE DISEASE*	_____	*ULCERS*	_____
CANCER	_____	*SWELLING OF ANKLES*	_____	*COLITIS*	_____
PNEUMONIA	_____	*URINARY PROBLEMS*	_____	*DIVERTICULITIS*	_____
GERD	_____	*BOWEL PROBLEMS*	_____	*HIGH BLD PRESS.*	_____
DIPHTHERIA	_____	*ARTHRITIS*	_____	*IBS*	_____
SLEEP LOSS	_____	*NERVOUSNESS*	_____	*SINUS*	_____
HEMORRHOIDS (PILES)	_____	*HEADACHES*	_____	*MIGRAINES*	_____
BACKACHES	_____	*DIZZINESS*	_____	*EMPHYSEMA*	_____
RESTLESS LEGS	_____	*DEPRESSION*	_____	*SLEEP APNEA*	_____

ANY OTHER CONDTIONS YOU HAVE HAD OR HAVE?:_____
HAVE YOU BEEN TREATED FOR ANY OTHER HEALTH CONDITIONS THIS YEAR?:_____ WHAT?:_____
_____
ARE YOU PREGNANT? YES___ NO___
WHAT SURGERIES HAVE YOU HAD?: TONSILS_____APPENDIX_____GALL BLADDER_____HEMORRHOIDS(PILES)_____
VASECTOMY_____ KNEE_____HIP_____SPINE_____CORONARY BYPASS_____CAROTID ARTERY_____
HYSTERECTOMY/ EXPLORATORY_____PARTIAL_____ COMPLETE_____
OTHER SURGERIES _____
HAVE YOU EVER HAD ANY BAD FALLS?: YES____NO____ *WHEN?*:_____
*DESCRIBE:*_____
HAVE YOU EVER BROKEN ANY BONES?: YES___NO___ *WHEN?*:_____
DESCRIBE: _____
HAVE YOU EVER BEEN IN A CAR ACCIDENT?: YES___ NO___ *WHEN?*:_____
*DESCRIBE:*_____
WHAT MEDICATIONS OR DRUGS ARE YOU TAKING?:_____
WHAT IS THE NAME OF YOUR MEDICAL PROVIDER?_____
WHO IS RESPONSIBLE FOR PAYMENT:_____
ARE YOU INSURED: YES____NO___ *COMPANY:*_____
HAVE YOU BEEN TO A CHIROPRACTOR BEFORE?: YES___ NO___ *WHO?*:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Bomonti will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the aforementioned doctor will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that 1% interest, per month, will be charged on accounts due over 30 days. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable.

PATIENTS SIGNATURE:_____S.S#_____DATE:_____
GUARDIAN OR SPOUSE'S
AUTHORIZING CARE SIGNATURE_____DATE:_____

DRIVERS LICENSE#:_____EXPIRATION DATE:_____

(IF YOU ARE HERE FOR A CAR ACCIDENT OR AN ON THE JOB INJURY THERE IS ANOTHER FORM TO COMPLETE)

Bomonti Chiropractic Office**11705 101st Ave E. **PO Box 73910**Puyallup WA 98373**253-848-1584

Bomonti Chiropractic

Informed Consent

Patient Name: _____ **File #:** _____

SPINAL MANIPULATION RISKS AND COMPLICATIONS

Spinal Manipulation has been proven to be a very safe procedure; in fact it is the safest of the three major forms of health care. Studies have indicated that your risk of suffering a serious complication following a manipulation is remote. This paper will discuss the most common possible risks associated with manipulation. The bottom line: Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise.

_____ _____

Fracture: Fractures caused from spinal manipulation are extremely rare, so rare that an actual number of incidences per manipulation has never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation is utilized for this type of patient.

_____ _____

TIA/Stroke: According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million adjustments. Screening tests are performed when necessary to rule out high-risk patients. Alternative spinal adjusting is utilized when necessary to minimize any potential risks.

_____ _____

Ruptured/Herniated Disc: There have been some reports of herniated or ruptured discs caused by spinal manipulation. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.

_____ _____

Other: _____

I have read this form and am fully aware of the potential risks associated with spinal manipulation and agree to undergo Chiropractic care.

Patient Name (please print):_____

Signed:_____ **Date:**_____

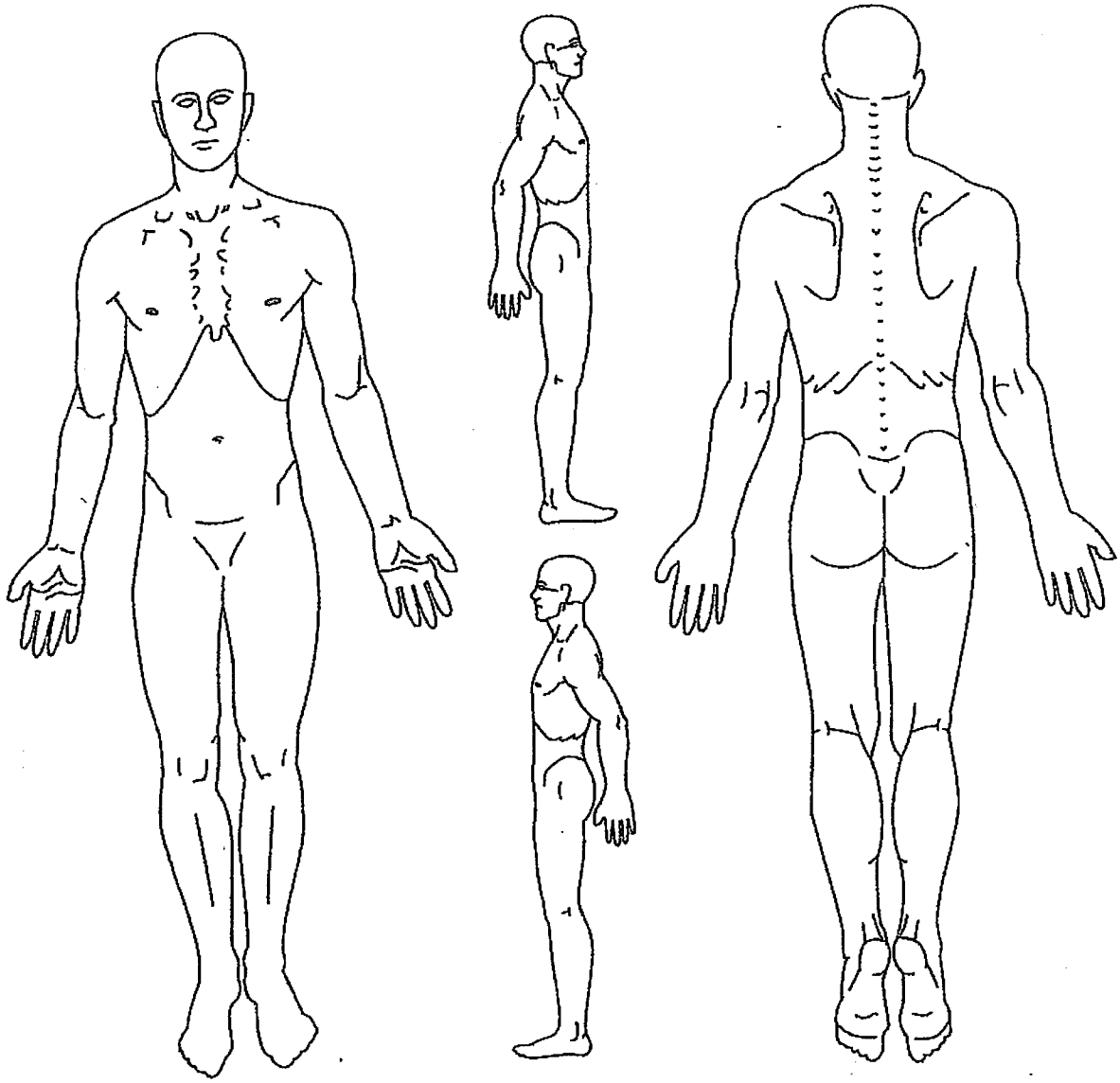
Signature of Doctor: _____ **Date:**_____

Patient Name(Print)_____ Date_____

Patient ID #_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull	S = Stabbing/Cutting
B = Burning	T = Tingling (Pins & Needles)
N = Numb	C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain