Welcome to our clinic,

Please fill out the information as much as possible, so we can understand your condition better and provide you with all the necessary services, and at the same time provide the best documentation for your claim.

Anything you do not remember or do not understand, or does not apply, you can leave it blank. We will help you fill the form out when you bring it in the clinic.

Thank you for choosing us to be part of your health care provider.
Dr. Sky and Dr. Jeudi Boulom

Dr. Sky Boulom, DC & Dr. Jeudi Boulom, DC
15608 18TH PL W Lynnwood, WA 98087 (425) 773-8553

Patient Name: _____

Address_____City_____ State _____ Zip Code _____

Cell Phone _____ H. Phone _____W. Phone_____

Email Address: _____

Sex: Male / Female Marital Status: Single / Married / Other

Date of Birth_____ Age_____ Social Security # _____

Emergency Contact Name: _____ Relationship: _____

Cell Phone _____ H. Phone _____W. Phone_____

ASSIGNMENT OF INSURANCE BENEFITS
SIGNATURE ON FILE

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this clinic chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The clinic will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

*I hereby authorize payment directly to Dr. Boulom
*I authorize Dr. Boulom to act as my agent in helping me to obtain payment from the Insurance Company.
*I understand that I am financially responsible to the charges not covered by this assignment.
*I authorize the doctor, attorney, or insurance company to release any information required for this claim.
*I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Patient/ Policy Holder

Dr. Sky Boulom, DC & Dr. Jeudi Boulom, DC
15608 18TH PL W Lynnwood, WA 98087 (425) 773-8553

Patient Name: _____

INFORMED CONSENT
CONSENT FOR TREATMENT

CHIROPRACTIC
Chiropractic is a health care system that promotes health by working with the body naturally. Chiropractic believes that the body has its own innate healing capability to heal itself, if the body is allowed to express itself in its optimal environment, by being free from subluxation. A subluxation is a minor misalignment or malfunction of the joints of the body to the extent that it puts pressure on the surrounding tissues, especially the nerve tissues, and causes problem where ever the nerves travel to, resulting in either over stimulation or under stimulation. Either condition causes an alteration in the normal function of the body, thus resulting in a loss of health. Many things in our daily life can cause subluxation in the body; it may be due to birth process, aging, injury, physical or emotional trauma, stress, chemical imbalance, activity of daily living, etc. Chiropractic corrects the subluxation by giving an adjustment. An adjustment involves the use of controlled force by hand or instrument. Other modalities may be given to help facilitate the healing of the body, to reduce the interferences in the body and restore the normal function. When the body is functioning at its optimum, then you will be healthy.

INFORMED CONSENT FOR CHIROPRACTIC CARE
I give Dr. Boulom, DC and Associates permission and authority to care for my condition in accordance with the chiropractic tests, diagnosis and analysis. Chiropractic treatment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, illnesses, or pathologies may render the patient susceptible to injury. I promise to inform Dr. Boulom, DC and Staff any time I feel my well-being is threatened or compromised. It is my responsibility to let the doctor know all the health condition I am suffering from. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. Dr. Boulom, DC and Associates will not give a chiropractic treatment, or health care, if he is aware that such care may be contraindicated. I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by Dr. Boulom, DC and Staff and other members of my health care team. I understand and agree that Dr. Boulom, DC and Associates have the right to refuse to accept me as a patient at any time before or after treatment begins, if I do not follow the recommendations and comply with the treatment schedules.

RESULTS
The results of chiropractic care depend on many variables; such as the status of your condition (acute or chronic), how traumatic is your condition, and your overall health. You should notice great improvement within two weeks into your care. In most cases there is a more gradual, but quite satisfactory response.

RETRACING
On rare occasion, especially when your body is fragile, retracing occurs before “true” healing can take place. Retracing is the release and healing of unresolved problems. After the correction, old injuries, old distortions, old subluxations and old symptoms (both physical and emotional) may resurface while the body is going through the unwinding process of healing.
Patients may report of having "cleansing" symptoms such as diarrhea, pus, mucus, headache, generalized ache and pain, fever, etc. as toxins leave the body. These symptoms may take the form of emotional releases, old memories coming up or unusual dreams.
It is very important, especially at this time, to maintain regular treatment schedule to facilitate the healing process.

Please discuss any question or concern you have with the doctor before signing this statement of policy.
I have read and understand this Informed Consent.

_____ _____
Signature Date
(Signature of parent or guardian if patient is a minor)

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Patient Name: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, we may provide any necessary reports or required information to aid in insurance reimbursement for the services rendered.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing, and fund-raising activities, and conduction or arranging for other business activities. We may also provide your protected health information to your attorney for status update and/or for helping with third party settlement. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

Dr. Sky Boulom, DC & Dr. Jeudi Boulom, DC
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Patient Name: _____

CAR ACCIDENT INFORMATION

Date: _____ Time of Accident: _____ ☐am ☐pm

Please describe the accident in your own words: _____
_____
_____
_____
_____

Were you the: ☐Driver ☐Front Passenger
☐Rear Passenger ☐Pedestrian (not in car)
How many people were in the car? _____
==========
Street Name _____
City/State _____
==========
Year / Make / Model of the car you were in:
_____
☐Car ☐SUV ☐Pickup Truck ☐Van
Were you wearing seatbelt?
☐Full lap and shoulder ☐Lap only
☐Shoulder only ☐No seatbelt
What position were your vehicle headrest in?
☐Lowest position ☐Middle position
☐Highest position ☐No headrest
Did your seat ☐Beak or ☐Bend? ☐Yes ☐No
Was vehicle equipped with airbags? ☐Yes ☐No
If yes, did it inflate properly? ☐Yes ☐No
What was your vehicle doing prior to accident?
☐Going Straight ☐Slowing down to a stop
☐At a complete stop ☐Increasing speed
☐Merging into traffic ☐Changing lanes
Speed traveling? _____ mph
Who hit who?
☐You were struck by another car
☐You struck another car
☐You struck a stationary object
What was your vehicles point of impact?
☐Left ☐Right ☐Front ☐Rear
☐Other _____
_____
==========
Year / Make / Model of the car you were in:
_____
☐Car ☐SUV ☐Pickup Truck ☐Van
What was other vehicle doing prior to accident?
☐Going Straight ☐Slowing down to a stop
☐At a complete stop ☐Increasing speed
☐Merging into traffic ☐Changing lanes
Speed traveling? _____ mph
What was the other vehicles point of impact?
☐Left ☐Right ☐Front ☐Rear
☐Other _____
_____

Were you prepared for the impact?
☐Came as complete surprise
☐Aware but not braced for collision
☐Aware and braced for collision
Position of head and neck prior to the impact:
☐Straight forward ☐Inclined
☐Rotated to the left ☐Rotated to the right
What happened to you during the impact?
☐Tensed for impact
☐Whipped forward/backward
☐Body torqued and twisted
☐Body thrown over seat
☐Body thrown from vehicle
☐Body pinned in vehicle
☐Body thrown from side to side
Did your body (head, chest, chin, shoulder, knee, etc.) hit anything (steering wheel, windshield, dashboard, roof, side door, window, other) ? ☐Yes ☐No If yes, explain _____
_____
_____
_____
_____
Body ☐Cut ☐Bruised ☐Contusion
_____
_____
_____
What was your mental/emotional state immediately following the accident?
☐Unconscious for _____ minutes
☐Disoriented ☐Shaken up
==========
Did police come to the accident site ☐Yes ☐No
Was a police report filed? ☐Yes ☐No
Was a traffic violation issued? ☐Yes ☐No
If yes, to whom? _____
How much does it cost to fix the car? $_____
What is damage of your car? _____
_____
_____
_____
Damage of the other car? _____
_____
_____
_____

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Patient Name: _____

HISTORY

1. **Did you feel pain immediately after the accident?** YES / NO
   If yes, location _____
   _____

2. **Any intervention, treatment, medication, surgery, or care you've sought for this injury:** YES / NO
   Hospital / Clinic / Doctor Name: _____
   None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Chiropractic Treatment / Massage / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician
   _____
   _____
   _____

3. **Since the Motor Vehicle Collision, have you experienced any of the following:**
   A. Loss of Range of Motion: Yes / No
      a. What body parts: _____
   B. Visual Disturbance : Yes / No □ blurring l/r □ floaters l/r □ vision loss l/r □ hypersensitivity l/r
      % of time: ___ % of time: ___ % of time: ___ % of time: ___

   C. Dizziness: Yes / No % of time: ____
   D. Anxiety: Yes / No % of time: ____
   E. Depression: Yes / No % of time: ____
   F. Difficulty Sleeping: Yes / No
   G. Headache Yes / No
   H. Concentration problem Yes / No

4. **Past Health History:**

   A. Please indicate if you have a history of any of the following:
   □ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
   □ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
   □ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other __
   □ None of the above

   B. Previous Injury or Trauma: (Pre-existing injury: symptomatic or not symptomatic prior to this injury)(No Treatment, Active Treatment, Treatment within 24 months, Treatment within 5 yrs.)
   _____
   _____
   _____

   Have you ever broken any bones? Which?
   _____
   _____

   C. Allergies:
   _____
   _____
   _____

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Patient Name: _____

D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

5. Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

_____

_____

Is there anything else in your past medical history that you feel is important to your care here?

_____

_____

_____

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Patient Name: _____

PATIENT SYMPTOMS

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes / No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes / No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward / bending neck backward / tilting head to left / tilting head to right / turning head to left / turning head to right / bending forward at waist / bending backward at waist / tilting left at waist / tilting right at waist / twisting left at waist / twisting right at waist / sitting / standing / getting up from sitting position / lifting / any movement / driving / walking / running / nothing / other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Chiropractic treatment / massage / Rest / ice / heat / stretching / exercise / pain medication / muscle relaxers / nothing / Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp / dull / achy / burning / throbbing / piercing / stabbing / deep / nagging / shooting / stinging / Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes / no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning / Afternoon / Evening / Night / Unaffected by time of day

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Patient Name: _____

Symptom: _____

- Intensity: 1 2 3 4 5 6 7 8 9 10 (worst)
- Frequency: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%

- When did the symptom begin? _____
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Patient Name: _____

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Patient Name: _____

Symptom: _____

- Intensity: 1 2 3 4 5 6 7 8 9 10 (worst)
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