DR. KIMBERLY JONES, D.C.

HEALTHY MIND, BODY, AND SPIRIT

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PATIENT REGISTRATION

Welcome to our clinic. We look forward to meeting you and helping you enhance your overall health and wellness. ***Please note: Due to patient sensitivities, please refrain from wearing colognes, perfumes and scents when visiting the office.***

(Confidential Health Information)

Date: _____

Are you on Medicare? _____ If yes, Social Security Number _____

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____ DOB _____ Age ____

Preferred Name _____ Gender _____

Status: Single _____ Married _____ Partnered ____ Widowed _____ Divorced _____ Separated _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Email _____

Occupation _____ Employer Name _____ Work Phone _____

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

SPOUSE, GUARDIAN, PARENT

Last Name _____ First Name _____ MI _____ DOB _____

Cell _____ Relationship _____

Occupation _____ Employer Name _____ Work Phone _____

Last Name _____ First Name _____ MI _____ DOB _____

Cell _____ Relationship _____

Occupation _____ Employer Name _____ Work Phone _____

CHILDREN

_____

_____

Pets _____

Who referred you in for care? _____

(continued…)

Patient Name: _____

CHIEF COMPLAINT

Reason for Visit? _____

How long have you had this condition? _____ Is it getting worse? Yes ____ No ____

Does it interfere with work _____ sleep _____ sports _____ other
_____

What seemed to be the initial cause? _____

Have you seen other doctors for this complaint? Yes ____ No ____ Name of Doctor _____

X-rays taken? Yes ____ No ____ Lab Work? Yes ____ No ____ Diagnostics Tests _____

Treatment _____Results
_____

Additional Complaint
_____

How long have you had this condition? _____ Is it getting worse? Yes ____ No ____

Does it interfere with work _____ sleep _____ sports _____ other
_____

What seemed to be the initial cause? _____

Have you seen other doctors for this complaint? Yes ____ No ____ Name of Doctor _____

X-rays taken? Yes ____ No ____ Lab Work? Yes ____ No ____ Diagnostics Tests _____

Treatment _____Results
_____

PATIENT HEALTH HISTORY

Have you:	Yes	No	If yes, explain briefly.
Been hospitalized in the last 5 years?	_____	_____	_____
Had any broken bones/sprains/strains?	_____	_____	_____
Had any trauma or accident?	_____	_____	_____

FAMILY HEALTH HISTORY

Check the conditions that apply to your family: mother, father, sister, brother, grandparents. Do not include yourself.

___ Cancer _____ ___ Arthritis _____

___ Diabetes _____ ___ Mental / Emotional _____

___ Heart Disease _____ ___ Kidney Disease _____

___ Obesity _____ ___ Other _____

(continued…)

Patient Name: _____

PATIENT HEALTH HISTORY

If any of the following apply to you, please indicate as follows: **P** for past conditions and **C** for current conditions.

GENERAL

P C
__ __ Headache
__ __ Fever
__ __ Chills
__ __ Night Sweats
__ __ Fainting
__ __ Dizziness
__ __ Loss of Sleep
__ __ Fatigue
__ __ Nervousness
__ __ Loss of Weight
__ __ Numbness/Pain in Arms/Legs/Hands

GASTROINTESTINAL

P C
__ __ Poor Appetite
__ __ Poor Digestion
__ __ Excessive Hunger
__ __ Belching or Gas
__ __ Nausea
__ __ Vomiting
__ __ Vomiting Blood
__ __ Pain over Stomach
__ __ Constipation
__ __ Diarrhea
__ __ Hemorrhoids
__ __ Liver Trouble
__ __ Jaundice

EYE/EAR/NOSE/THROAT

P C
__ __ Poor Vision
__ __ Crossed Eyes
__ __ Pain in Eyes
__ __ Deafness
__ __ Earache
__ __ Ear Noises
__ __ Nasal Obstruction
__ __ Nose Bleeds
__ __ Sore Throat
__ __ Sinus Trouble
__ __ Frequent Colds
__ __ Enlarged Thyroid
__ __ Tonsillitis

RESPIRATORY

P C
__ __ Chronic Cough
__ __ Spitting Phlegm
__ __ Spitting Blood
__ __ Chest Paint
__ __ Difficulty Breathing
__ __ Hay Fever
__ __ Wheezing
__ __ Asthma

GENITOURINARY

P C
__ __ Frequent Urination
__ __ Painful Urination
__ __ Blood in Urine
__ __ Kidney Infection
__ __ Bed Wetting
__ __ Inability to Control Urine
__ __ Prostrate Trouble

MUSCLES & JOINTS

P C
__ __ Arthritis/Rheumatism
__ __ Bursitis
__ __ Foot Trouble
__ __ Muscle Weakness
__ __ Low Back Pain
__ __ Neck Pain
__ __ Mid Back Pain
__ __ Joint Pain
__ __ Painful Tailbone
__ __ Hernia

CARDIOVASCULAR

P C
__ __ Rapid Heart Beat
__ __ Slow Heart Beat
__ __ High Blood Pressure
__ __ Low Blood Pressure
__ __ Pain Over Heart
__ __ Swelling Ankles
__ __ Poor Circulation
__ __ Varicose Veins
__ __ Strokes

SKIN OR ALLERGIES

P C
__ __ Skin Eruptions
__ __ Itching
__ __ Bruising Easily
__ __ Dryness
__ __ Boils
__ __ Sensitive Skin
__ __ Hives or Allergies
__ __ Eczema
__ __ Rash
__ __ Cold Sores

WOMEN ONLY

P C
__ __ Excessive Flow
__ __ Irregular Cycles
__ __ Hot Flashes
__ __ Cramps or Backache
__ __ Vaginal Discharge
__ __ Miscarriage
__ __ Painful Periods

Last Pap ____/____/____

Check all of the conditions below that you have experienced:

__ Alcoholism
__ Anemia
__ Appendicitis
__ AIDS
__ Cancer
__ Chicken Pox
__ Diabetes
__ Diphtheria
__ Emphysema
__ Epilepsy
__ Goiter
__ Gout
__ Heart Disease
__ Hepatitis
__ Influenza
__ Malaria
__ Measles
__ Mental/Emotional Disorders
__ Multiple Sclerosis
__ Mumps
__ Pneumonia
__ Polio
__ Scarlet Fever
__ Smallpox
__ Stroke
__ Tuberculosis
__ Typhoid Fever
__ Ulcers
__ Venereal Disease
__ Whooping Cough

(continued…)

Patient Name: _____

PATIENT HEALTH INFORMATION

Blood Type _____

Hours of sleep _____ General time you go to bed _____ Time arise _____

Are you rested when you arise? _____ Explain _____

Do you fall asleep easily? _____ Do you wake up during the night? _____ What time? _____ Can you fall back to sleep? _____

Is there any light in the room when you sleep? _____

What are your work hours? _____ Days of the week? _____Type of work? _____

Do you exercise? _____ Number of days per week? _____Length of workout _____

Type of exercise _____

Do you drink?

Water	_____	Glasses per day	_____
Alcohol	_____	Servings per week	_____
Soda	_____	Servings per week	_____
Coffee	_____	Servings per week	_____

Do you eat?

Salty foods _____ Sugar _____ Red Meat _____ Pork _____ Vegetables _____ Fruit _____

Do you crave any of these foods? _____ Which ones? _____
Do you smoke? _____ Packs per day _____ Age when started _____

Did you have?

Colic as an infant? _____ Did your siblings or children? _____
Ear infections or tubes as a child? _____ Did your siblings or children? _____
Allergies _____ to what? _____

Did/do your siblings or children have allergies? _____

List all prescription meds _____

_____

Over the counter meds _____

Vitamins _____

Have you had any chemical exposures? _____ Explain _____

Have you had any mold exposures? _____ Explain _____

List all states and countries where you have lived _____

Education _____

Religious/Spiritual preference _____

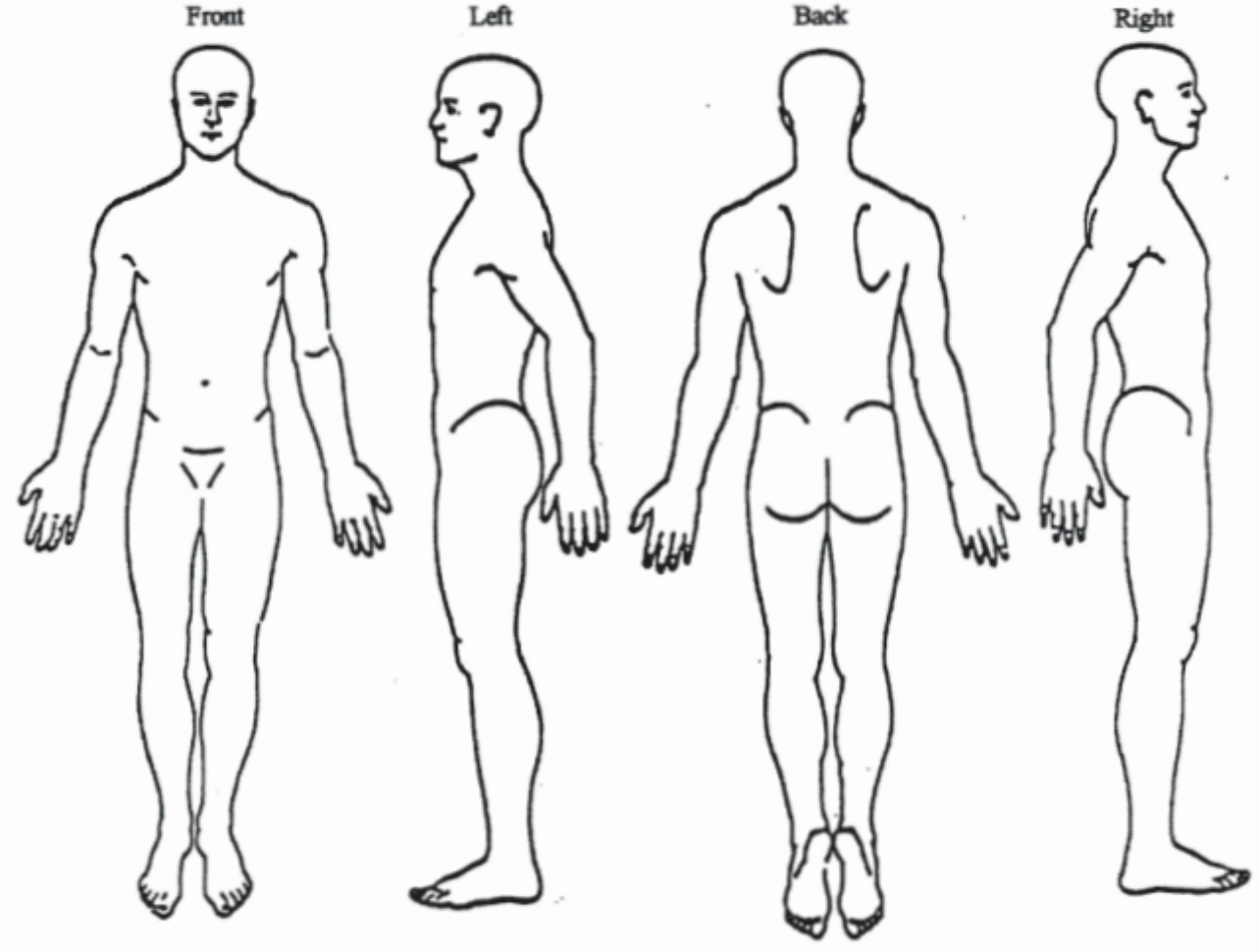
(continued…)

Patient Name: _____

PAIN DRAWING

Using the following descriptive symbols, draw the location of your pain on the body outlines below. In addition, mark the level of your pain on the line at the bottom of the page.

Aching or Dull	Burning	Numbness	Tingling/ Pins & Needles	Sharp or Stabbing	Other
^^^^	XXXX	OOOO	.....	//////////	------
^^^^	XXX	OOO	....	/////	---



Please make a slash through the below line to indicate the level of your pain:

I HAVE NO PAIN WORST POSSIBLE PAIN

Paitent Signature _____

(continued…)

FINANCIAL AGREEMENT

I claim full financial responsibility for the services rendered by Dr. Kimberly Jones and understand that the payment is required in full at the time of service.

Patient Name

Date

Signature of Patient or Parent of Minor

Relationship to Patient

(continued…)

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PATIENT CONSENT

Osseous and Soft Tissue Manipulation

(Consent to Treatment)
Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular that you should note:

While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.

There have been rare reported cases of disc injuries following cervical or lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are causes, or may be caused by spinal or soft tissue manipulation or treatment.

There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasions result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and has demonstrated to be a highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well-being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my health care provider:

The condition that the treatment is to address
The nature of the treatment
The risks and benefits of the treatment
Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatment offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intent to consent to apply to all my present and future care with _____ (healthcare provider's name).

Dated this _____ day of _____ 20 _____

_____ Patient signature (or Legal Guardian)

_____ Signature of Witness

Printed Name: _____

Printed Name: _____