KIMBERLY N. JONES, D.C.
HEALTHIER MIND, BODY & SPIRIT

PATIENT REGISTRATION

Welcome to our clinic. We look forward to meeting you and helping you enhance your overall health and wellness. Our office manager, Claudette Overfield, will be happy to assist you with any questions.

Please note: Due to patient sensitivities, please refrain from wearing colognes, perfumes, and scents when visiting the office.

2739 Bachman Drive Dallas, TX 75220
Office 214.366.1133 Fax 214.366.3916 DrKimberlyJones.com

(Confidential Health Information)

Are you on Medicare? ____ If yes, Social Security number ______________________________ Date______________________

PATIENT INFORMATION

Last name ________________________________ First __________________________ 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 _____________________________ Home phone _________________ Cell ___________________ Relation _____________

SPOUSE, GUARDIAN, PARENT

Last name ________________________________ First __________________________ MI ______ DOB ____________________

Cell ___________________________ Relationship ____

Occupation ______________________________ Employer name ___________________________ Work phone ________________

Last name _________________________________ First __________________________ MI ______ DOB ____________________

Cell ___________________________ Relationship ____

Occupation ______________________________ Employer name ___________________________ Work phone _______________

CHILDREN (NAME AND AGE)

____

____

Pets ____

Who referred you in for care?____

(continued...)

Patient Name: ____

CHIEF COMPLAINT

1. 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 ___ Diagnostic tests ______________________________

Treatment ______________________________ Results ______________________________

2. 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 ___ Diagnostic 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 ______________________________

__ Diabetes ______________________________

__ Heart Disease ______________________________

__ Obesity ______________________________

__ Arthritis ______________________________

__ Mental/Emotional ______________________________

__ Kidney Disease ______________________________

__ 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 Pain
__ __ Difficulty Breathing
__ __ Hay Fever
__ __ Wheezing
__ __ Asthma

GENITOURINARY

P C

__ __ Frequent Urination
__ __ Painful Urination
__ __ Blood in Urine
__ __ Kidney Infection
__ __ Bed Wetting
__ __ Inability to Control Urine
__ __ Prostate 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

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

Last Pap ____/____/______

Check all of the conditions 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 where 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 ____________________

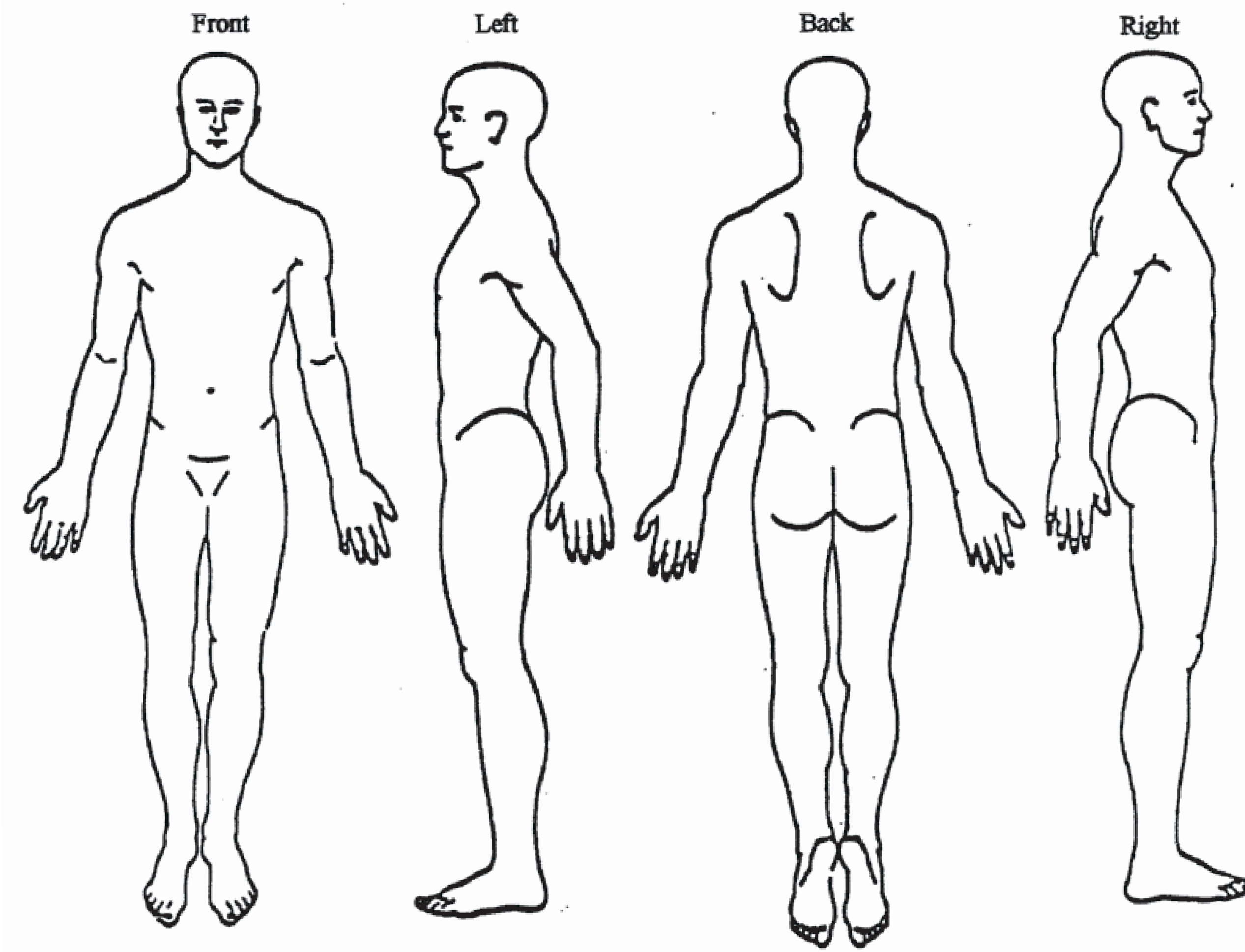
(continued...)

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 XXX	OOOO OOO	....	//////// /////	------ ---



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

I HAVE NO PAIN ______________________________ WORST POSSIBLE PAIN

Patient Signature ______________________________

(continued...)

FINANCIAL AGREEMENT

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

____
Patient's name

____
Date

____
Signature of Patient or Parent of Minor

____
Relationship to Patient

(continued...)

PATIENT CONSENT

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(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 you should note:

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

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

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, 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 have demonstrated it to be 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 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; and
d. Any alternatives to that treatment.

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

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with ____________________________________ (health care providers name).

Dated this ___________ day of _____________ 20___

____
Patient signature (or Legal Guardian)

Print Name:____________________________________

____
Signature of Witness

Print Name:________________________________