

ELEMENTS OF HEALTH, INC
DR. KATHLEEN A. JONES, D.C., N. D.

NATUROPATHIC PHYSICIAN
PHONE: 614-888-4372
FAX: 614-888-6372

7870 OLENTANGY RIVER RD, SUITE 208
COLUMBUS, OH 43235
EMAIL: drjones@eohinfo.com

DEAR NEW PATIENT:

WELCOME TO OUR OFFICE! WE ARE EXCITED TO HELP YOU ON YOUR ROAD BACK TO GOOD HEALTH!

ENCLOSED IS YOUR NEW PATIENT QUESTIONNAIRE AND PATIENT SYMPTOMS SURVEY THAT MUST BE COMPLETED PRIOR TO YOUR APPOINTMENT DATE. **PLEASE BRING THESE FORMS WITH YOU TO YOUR CONSULTATION.** YOUR PUNCTUALITY ON THIS DAY WILL ENSURE THAT YOU HAVE THE FULL TIME ALLOTTED FOR YOU TO SPEND WITH DR. JONES.

DR. JONES HAS BEEN PRACTICING IN THE COLUMBUS AREA FOR OVER 20 YEARS. SHE GRADUATED FROM LIFE CHIROPRACTIC COLLEGE IN 1986 WITH A BACHELOR OF SCIENCE DEGREE IN NUTRITION AND A DOCTORATE IN CHIROPRACTIC. IN 1998 SHE EARNED A NATUROPATHIC MEDICAL DOCTOR DEGREE FROM CENTRAL STATES COLLEGE OF NATUROPATHY.

PLEASE NOTE THAT WE DO NOT BILL INSURANCE. WE ARE HAPPY TO PROVIDE YOU WITH A RECEIPT FOR YOU TO SEND IN TO YOUR INSURANCE COMPANY. IF FURTHER INFORMATION IS NEEDED WE CHARGE \$10.00 PER PAGE. **PAYMENT IS EXPECTED AT THE TIME OF SERVICE.**

WE LOOK FORWARD TO SEEING YOU! IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL OUR OFFICE.

YOURS IN GOOD HEALTH,

APPOINTMENT TIME/ DAY:

DR. KATHLEEN A. JONES

Leaves of Life & Elements of Health

Policies and Procedures

Cancellation Policy

A block of time has been set aside for each appointment and this time is usually lost when last minute changes are made. Therefore, we require a **24 business hour notice** to cancel or change a follow-up appointment and a **48 business hour notice** to cancel a new client appointment. Any appointments cancelled with less than the required notice will be charged a \$50 missed appointment fee. To remind you of upcoming appointments, our staff will call you 1-3 days in advance of your appointment. These calls are a courtesy call and should be not relied upon to keep track up upcoming appointments.

To cancel or reschedule an appointment, please call (614) 888-4372. The phone is date and time-stamped for your convenience, so you may call at any time to cancel or reschedule an appointment. If you reach our voicemail, please leave a message and someone will return your call as soon as possible. Voicemail is checked frequently during business hours.

Office Hours:

Monday – Thursday 9:30a.m.-6:00p.m.

Friday – 9:30a.am.-4:00p.m.

Financial Policy

Payment is due in full at time of service.

Product Returns

Any returned product must be unopened and not expired and will be refunded at 80% of purchase price. Products that are special-ordered are non-returnable.

Test Kits

Prepaid test kits are non-refundable once removed from the office.

Returned Checks

There is a \$25 fee for any returned checks.

Questions between Appointments

For clients who are *regularly* seeing any of our practitioners, questions that arise between appointments are considered included in the cost of initial and follow-up consultations. However, please be respectful of the practitioners' time and limit questions to only those that cannot wait until the next consultation time. Each practitioner reserves the right to request that you take extensive questions and concerns to a paid phone or office consultation.

Signature of Client (or parent/legal guardian)

Date

Printed Name of Client (or parent/legal guardian)

ELEMENTS OF HEALTH, INC.
DR. KATHLEEN JONES DC, ND
PATIENT NUTRITION QUESTIONNAIRE

Name _____ Date of Birth _____ SS# _____
Address _____ City _____ State _____
Email _____ Zip Code _____
Telephone: Home _____ Work _____
Place of Employment _____ Occupation _____
Married ___ Single ___ Divorced ___ Widow(er) ___ # Of Children _____
Spouse's Name _____ Place of Employment _____
In Case of Emergency, whom should we contact?
Name _____ Phone _____ Relationship _____
How did you hear about our office? _____

We will provide a receipt for you to submit to your insurance. You are responsible for payment in full at the time of service.

** I clearly understand that all services rendered me are my responsibility and payment is expected at the time of service.

Patient's Signature _____ Date _____
If under 18 years of age, parent or guardian's signature _____

Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended. Section 201 (g) (1) The term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug, neither is a Mineral, Trace Element, Amino Acid, Herb or a Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that It can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not Intended as a primary treatment and/ or therapy for any disease or particular bodily Symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive Schedule of nutrition is provided solely to upgrade the quality of foods in the patient's Diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above:

Signature _____ Date _____

PATIENT SYMPTOM SURVEY

DATE _____

PATIENT'S NAME _____ AGE _____

WEIGHT _____ HEIGHT _____ BLOOD PRESSURE _____ PULSE _____ O₂ _____

This is a confidential patient symptom survey. Please check each condition which is true for you. If the condition does not apply to you or you do not understand a term or if you are not sure if a condition applies to you, then do not check the box. Use common sense. For example, Insomnia once in the last month probably isn't that important and would not be marked. However, Insomnia occurring 1-2 times per week is notable and would be marked. Please take your time...

Primary Complaints

- | | | |
|---|--|--|
| 090 <input type="checkbox"/> General Good Health
091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis
001 <input type="checkbox"/> Skin Disorder 692.9
002 <input type="checkbox"/> Acne 706.1
003 <input type="checkbox"/> Psoriasis 696.1
004 <input type="checkbox"/> Urticaria (Hives) 708.9
005 <input type="checkbox"/> ADD/ADHD 314.00/314.01
006 <input type="checkbox"/> Allergies, Unspecified 477.9
007 <input type="checkbox"/> Allergic Rhinitis from food 477.1
008 <input type="checkbox"/> Sinusitis 461.9
009 <input type="checkbox"/> Alzheimer's 331.0
010 <input type="checkbox"/> Poor Concentration/ Memory 310.1
011 <input type="checkbox"/> Parkinson's Disease 332.0
012 <input type="checkbox"/> Anemia 285.9
013 <input type="checkbox"/> Arthritic Disorder 716.90
014 <input type="checkbox"/> Osteoporosis 733.00
015 <input type="checkbox"/> Asthma 493.90
016 <input type="checkbox"/> Emphysema 492.8
017 <input type="checkbox"/> Cancer
018 <input type="checkbox"/> Breast 174.9female 175.9male
019 <input type="checkbox"/> Prostate 185
020 <input type="checkbox"/> Lung 162.9
021 <input type="checkbox"/> Colon and Rectal 153.9
022 <input type="checkbox"/> Skin 173.9
023 <input type="checkbox"/> Leukemia w/o remission 208.90
Leukemia w/ remission 208.91
024 <input type="checkbox"/> Lymphoma, malignant 202.8
025 <input type="checkbox"/> Brain Tumor, malignant 191.9
027 <input type="checkbox"/> Anxiety Disorder 300.00
028 <input type="checkbox"/> Autism 299.00
033 <input type="checkbox"/> Edema 782.3
034 <input type="checkbox"/> Eczema 692.9
035 <input type="checkbox"/> Chronic Fatigue 780.71
036 <input type="checkbox"/> Circulatory Disorder 459.9
037 <input type="checkbox"/> Heart Disease 429.9
038 <input type="checkbox"/> High Cholesterol 272.0
039 <input type="checkbox"/> High Blood Pressure 401.9 | 040 <input type="checkbox"/> Low Blood Pressure 458.9
041 <input type="checkbox"/> Tachycardia (High Heart Rate) 785.00
042 <input type="checkbox"/> Numbness 782.0
043 <input type="checkbox"/> Constipation 564.0
044 <input type="checkbox"/> Indigestion 536.8
045 <input type="checkbox"/> Ulcerative Colitis 556.9
046 <input type="checkbox"/> Depression 311
047 <input type="checkbox"/> Diabetes Mellitus 250.0
030 <input type="checkbox"/> Diabetes Type I 250.01
031 <input type="checkbox"/> Diabetes Type II 250.02
029 <input type="checkbox"/> Hyperglycemia [high blood sugar] 790.29
048 <input type="checkbox"/> Hypoglycemia [low blood sugar] 251.2
049 <input type="checkbox"/> Dizziness/Balance Problem 780.4
050 <input type="checkbox"/> Ear Infection 381.4
051 <input type="checkbox"/> Epstein Barr 075
052 <input type="checkbox"/> Eye Problems 379.91
053 <input type="checkbox"/> Cataracts 366.9
054 <input type="checkbox"/> Glaucoma 365.9
055 <input type="checkbox"/> Macular Degeneration 362.50
056 <input type="checkbox"/> Fever 780.6
057 <input type="checkbox"/> Fibromyalgia 729.1
058 <input type="checkbox"/> Gallbladder Disorder 575.9
059 <input type="checkbox"/> Gout 274.9
060 <input type="checkbox"/> Headaches 784.0
061 <input type="checkbox"/> Hearing Loss 389.9
062 <input type="checkbox"/> Infertility, male 606.9
064 <input type="checkbox"/> Liver Disease 571.9
065 <input type="checkbox"/> Hepatitis 573.3
066 <input type="checkbox"/> Hepatitis B 070.30
067 <input type="checkbox"/> Hepatitis C 070.51
068 <input type="checkbox"/> Kidney Disorders 593.9 or Bladder Disorder 596.9
063 <input type="checkbox"/> Prostate Disorder 602.9
069 <input type="checkbox"/> Hyperthyroidism 242.90 | 070 <input type="checkbox"/> Hypothyroidism 244.9
071 <input type="checkbox"/> Systemic Lupus 710.0
072 <input type="checkbox"/> Infertility, female 628.9
073 <input type="checkbox"/> Interstitial Cystitis 595.1
074 <input type="checkbox"/> Irregular Menstrual Cycle 626.4
075 <input type="checkbox"/> Menopausal Symptoms 627.2
076 <input type="checkbox"/> Hot Flashes 627.2
077 <input type="checkbox"/> Mental Disorder 300.9
078 <input type="checkbox"/> Insomnia 780.52
079 <input type="checkbox"/> Mouth/Throat/Tongue
080 <input type="checkbox"/> Canker Sores 528.2
081 <input type="checkbox"/> Overweight 278.02
082 <input type="checkbox"/> Underweight 783.22
083 <input type="checkbox"/> Sexual Disorder 302.89
084 <input type="checkbox"/> Spinal Problems 724.9
085 <input type="checkbox"/> Obesity 278.00
086 <input type="checkbox"/> GERD 530.81
087 <input type="checkbox"/> HIV 042
088 <input type="checkbox"/> Crohn's Disease 555.9
089 <input type="checkbox"/> Irritable Bowel Syndrome 564.1
092 <input type="checkbox"/> Normal Pregnancy v22.2
**only applicable if currently pregnant
093 <input type="checkbox"/> Shingles 053.9
140 <input type="checkbox"/> Migraines 346.90
141 <input type="checkbox"/> Rheumatoid Arthritis 714.0
142 <input type="checkbox"/> Non-Systemic Lupus 695.4
143 <input type="checkbox"/> Multiple Sclerosis 340
144 <input type="checkbox"/> ALS Lou Gerigs disease 335.20
145 <input type="checkbox"/> Polymyalgia Rheumatica 725
146 <input type="checkbox"/> Scleroderma 710.1
171 <input type="checkbox"/> Goiter 240.9
178 <input type="checkbox"/> Raynaud's Syndrome 433.8
179 <input type="checkbox"/> Hemochomatosis 275.0
180 <input type="checkbox"/> Thalassemia 282.49
181 <input type="checkbox"/> Brain aneurysm 431 |
|---|--|--|

If necessary, please state your most significant concern...

General Health

- 100 Fingernail base is pink
 - 101 Fingernail base is purple
 - 102 Fingernails have ridges or white spots
 - 103 Fingernails are soft
 - 104 Fingernails are splitting
 - 105 Fingernails peel
 - 106 Pale fingernail beds
 - 107 Blacks out easily
 - 108 Balance problems
 - 109 Difficulty walking
 - 110 Has tattoos
 - 111 Brittle hair
 - 112 Dry hair
 - 113 Thin hair
 - 114 Hair loss
 - 115 Drinks alcoholic beverages daily
 - 116 Drinks less than 8 glasses of water per day
 - 117 Currently on Chemotherapy
 - 118 Currently on radiation treatment
 - 148 Had radiation therapy in the last year
 - 149 Had chemotherapy in the last year
 - 119 Had chemotherapy in the past
 - 120 Has had radiation treatments in the past
 - 121 Gained over 20 lbs in the last 12 months
 - 122 Somewhat Overweight
 - 123 Somewhat Underweight
 - 124 Unexplained weight loss of over 20lbs within the last 4 months
 - 125 Energy level is worse than it was 5 years ago
 - 127 Sleeps less than 6 hours per night
 - 128 Unable to recall dreams the next day
 - 129 Sensitive to chemicals, paint, fumes, cologne
 - 130 Had blood transfusion in the past
 - 131 Had transplant in the past
 - 138 Takes anti-rejection drugs
 - 132 Had a major accident or injury
 - 137 Sleep Apnea
 - 139 Toxic chemical exposure
 - 175 Has been out of the country recently
 - 176 Had childhood vaccines
 - 177 Had a vaccine in the last 12 months
 - 147 Had a flu shot last year
 - 182 Had a pneumonia vaccine last year
 - 183 Had a Hepatitis B vaccine in the last 2 years.
- Has a family history of:
- 184 Cancer
 - 185 Heart Disease
 - 186 Diabetes
 - 187 Alcoholism
 - 188 Depression
 - 189 Obesity

Lifestyle Habits

- 380 Drinks beverages from a can
- 370 Drinks alcohol
- 371 Drinks caffeinated coffee
- 372 Drinks caffeinated pop/soda
- 373 Drinks caffeinated tea
- 374 Drinks decaffeinated coffee
- 375 Drinks decaffeinated pop/soda
- 376 Drinks decaffeinated tea
- 377 Drinks more than 3 cups of coffee per day
- 378 Drinks more than 3 cups of tea per day
- 388 Drinks diet pop/soda
- 379 Drinks 1 or more pop/sodas per day
- I had 4 alcoholic drinks in one day:
 - 172 never
 - 173 more than 3 months ago
 - 174 less than 3 months ago
- 381 Has more than 5 alcoholic drinks per week
- 391 Craves sugar / starches
- 382 Currently smokes
- 383 Quit smoking in the last 5 years
- 384 Smoked for more than 5 years
- 385 Smokes more than 1 pack per day
- 126 Rarely exercises
- 133 Regularly exercises
- 386 Takes Vitamins
- 134 Vegetarian
- 135 Eats no red meat
- 136 Eats no meat, no dairy
- 387 Frequent use of artificial sweeteners
- 389 Anorexia
- 390 Bulimic

Surgeries

- 700 Tonsillectomy and/or Adenoids
- 701 Appendix
- 702 Gallbladder
- 703 Thyroid
- 715 Radiated thyroid
- 708 Cancer
- 704 Hysterectomy, complete
- 705 Hysterectomy, partial
- 706 Tubal ligation
- 707 Breast implants
- 709 Coronary by-pass
- 710 Spinal surgery
- 711 Extremity surgery
- 712 Hip replacement
- 713 Knee replacement
- 714 Splenectomy
- 716 Cataract surgery
- 717 Hemorrhoidectomy

Gastrointestinal

- 265 4-5 bowel movements per week
- 266 3 or less bowel movements per week
- 267 6 or more bowel movements per week
- 268 Black tarry stools
- 269 Pale or yellow colored stool
- 270 Blood stools
- 271 Constipation
- 272 Hemorrhoids
- 273 Loose bowel movements
- 274 Frequent diarrhea
- 275 Frequent nausea
- 276 Frequent vomiting
- 277 Abdominal gas
- 278 Belching and burping after eating
- 279 Bloating after eating
- 280 Severe abdominal pains
- 281 Stomach ulcers
- 282 Uses digestive aids
- 283 Uses laxatives
- 284 Immediate indigestion upon eating
- 285 Indigestion in 2 hours or more after meals
- 286 Indigestion within 1 hour after meals
- 287 Difficulty swallowing
- 288 Eating relieves fatigue
- 289 Eats when nervous
- 290 Excessive hunger
- 291 Poor appetite
- 292 Experiences fainting spells when hungry
- 293 Feels shaky when hungry
- 294 Frequently drowsy after eating a meal
- 295 Gall bladder disease
- 296 Has had intestinal worms
- 297 Reflux/Hiatal hernia
- 298 Liver disease
- 299 Irritable Bowel Syndrome
- 300 Diverticulitis
- 301 Diverticulosis

Respiratory

- 485 Catches severe colds
- 486 Chronic chest condition
- 487 Chronic cough
- 488 Constant runny nose
- 489 COPD
- 490 Difficulty breathing
- 491 Frequent colds
- 492 Frequent nose bleeds
- 493 Frequent sinus infections
- 494 Frequent stuffy nose
- 495 Hay fever
- 496 Nasal polyps
- 497 Night sweats
- 498 Post nasal drip
- 499 Sneezing spells
- 500 Spits up blood
- 501 Spits up phlegm
- 502 Wheezes

Mouth and Throat

- 400 **Bad breath**
- 401 Bitter taste in the mouth in the morning
- 402 Dry mouth
- 403 Excessive saliva
- 404 Sores or cracks in the corners of the mouth
- 405 Glands often swell
- 406 Frequent canker sores
- 407 Frequent fever blisters
- 408 Frequent sore throats
- 409 Frequently has a sore tongue
- 410 Sore gums
- 411 Swollen gums
- 412 Swollen tongue
- 413 Tongue burns
- 414 Tongue has grooves or fissures
- 415 Tongue is coated
- 416 Gums bleed when brushing teeth
- 417 Toothaches
- 418 Amalgam dental fillings
- 420 Other dental fillings (gold, composite, etc)
- 419 Has had root canal(s)

Endocrine

- 245 Coarse hair
246 Coarse skin
247 Diabetic
248 Excessive thirst
249 Frequently feels cold
250 Frequently feels hot
251 Gets lightheaded when standing quickly
252 Heals slowly
253 Unusually jumpy or nervous
254 Unusually tired most of the time

Cardiovascular

- 190 Cold feet
191 Cold hands
192 Experiences shortness of breath while sitting still
193 Heart skips beats
194 Tendency of High blood pressure
195 Leg cramps during bedtime
196 Leg cramps during daytime
197 Low blood pressure at times
198 Pain in leg/hips when walking
199 Frequent swollen ankles
200 Pains in the heart or chest
201 Spells of rapid heart rate
202 Troubled with blood clots
203 Unusually slow pulse rate
204 Varicose veins
205 Heart palpitations

Skin

- 520 Bruises easily
521 Excessive perspiration
522 Frequent goose bumps
523 Has acne
524 Has Psoriasis
525 Hives
526 Itchy skin
527 Problems with Eczema
528 Has moles which are changing in size and/or color
530 Skin is rough, especially on the back of the arms
529 Skin eruptions
531 Skin is tender
532 Sores that heal slowly
533 Troubled with boils
534 Dry skin

Ears

- 220 Discharge from ears
221 Hard of hearing
222 Punctured ear drum
223 Recurrent ear infection
224 Ringing or noises in the ears
225 Tinnitus

Eyes

- 320 Bloodshot eyes
321 Blurred vision
322 Cross eyes
323 Eye pain
324 Eyes feel gritty
325 Eyes watery
326 Mild Glaucoma
327 Far sighted
328 Developing cataracts
329 Mild Macular degeneration
330 Itchy eyes
331 Near sighted
332 Dry Eyes

Feet

- 350 Corns
351 Frequent foot cramps
352 Heel spurs
353 Painful feet
354 Plantar warts
355 Swelling in the feet and/or ankles
356 Plantar fasciitis
357 Fungal Infection

Neuromuscular

- 440 Bites nails
441 Frequent muscle soreness
442 Muscle spasms
443 Muscle weakness
444 Tremors
445 Frequent headaches
446 Often dizzy
447 Frequently feels faint
448 Has Epilepsy
449 Has motion sickness
450 Has Osteoarthritis
451 Has Rheumatism
452 Rheumatoid Arthritis
453 Joint stiffness in the morning
454 Swollen joints
455 Leg pain at rest
456 Spinal curvature
457 Low back pain
458 Neck pain
459 Pain between the shoulders
460 Shoulder/arm pain
461 Numbness/tingling in the body
462 Sleep walks
463 Stutters or stammers
464 Nerve pain

Behavior Patterns

- 150 Afraid to eat anywhere except home
- 151 Always needs someone to advise
- 152 Cries often
- 153 Difficulty concentrating
- 154 Difficulty falling asleep
- 155 Difficulty staying asleep
- 156 Easily angered
- 157 Feelings are easily hurt
- 158 Frequently becomes scared for no reason
- 159 Frequently miserable or blue
- 160 Has to be on guard even with friends
- 161 Often annoyed by people
- 162 Recurrent bad dreams
- 163 Sometimes wishes to be dead or away from it all
- 164 Upset by criticism
- 165 Poor memory
- 166 Scared to be alone
- 167 Strange people or places cause fear
- 168 Under considerable emotional stress
- 169 Unhappy when other are happy
- 170 Brain fog

Urinary

- 555 Urinates more than 2 times per night
- 556 Bed wetting
- 557 Blood in the urine
- 558 Difficulty starting urination
- 559 Painful urination
- 560 Frequent urination
- 561 Troubled by urgent urination
- 562 Incontinence when sneezing or laughing
- 563 Loses bladder control
- 564 Frequent bladder infections
- 565 Frequent kidney infections
- 566 Kidney stones

Men Only

- 585 Difficulty completing intercourse
- 586 Difficulty getting or keeping an erection
- 587 Discharge from the urethra
- 588 Had a vasectomy
- 589 Had difficulty fathering children
- 590 Lumps in the testicles
- 591 Painful genitals
- 592 Prostate troubles
- 593 Sores on external genitalia
- 594 Herpes
- 595 Sexual diseases

Women Only

- 610 Heavy hair growth on face or body
- 611 Cycles are every 27-29 days
- 612 Abnormal cycle >29 days and/or <26 days
- 613 PMS
- 614 Menstrual cramps
- 615 Painful periods
- 616 Acne worse at menstruation
- 617 Excessive menstrual flow
- 618 Retains fluid during periods
- 619 Pre-menstrual depression
- 620 Currently taking birth control medication
- 621 Has taken birth control medication more than 1 year
- 622 Has taken birth control medication within the last year
- 623 Has had miscarriage
- 624 Hot flashes
- 625 Takes hormone replacement medication
- 627 Diminished sexual desire
- 628 Painful intercourse
- 629 Poor or infrequent orgasm
- 630 Lumps in the breasts
- 631 Tender breasts
- 633 Vaginal discharge
- 634 Bloody spotting discharge
- 635 Yeast infections
- 636 Sores on external genitalia
- 637 Herpes
- 638 Sexual diseases
- 639 Endometriosis
- 640 Breast reduction
- 641 Breast augmentation
- 642 Abortion
- 643 D&C
- 644 Tubal pregnancy
- 645 Uterine fibroids
- 646 Ovarian fibroids
- 647 Breast fibroids
- 648 Currently Breastfeeding

Medications

Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all drugs taken within the last five years including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement you are taking.

VITAMIN/HOW MUCH/BRAND

WEIGHT HISTORY Cont.

HAVE YOU REDUCED IN THE PAST:	NO	YES	Details of "yes" answers. (Identify item)
With medicine			
With diet			
With diet program List _____			
What year(s) _____ What results _____			
When did weight return _____			
DO YOU:	NO	YES	
Eat breakfast			
Eat lunch			
Eat dinner			
Eat between meals			
Eat at night			

In the list of foods below, check the amounts you usually eat over a week's period.

	Large	Moderate	Small	None		Large	Moderate	Small	None
Meat					Macaroni				
Fish					Spaghetti				
Cheese					Noodles				
Eggs					Beans				
Milk					Potato chips				
Soft drinks					Pretzels				
Coffee					Ice cream				
Bread					Cookies				
Cereal					Peanut butter				
Pastries					Jelly & jam				
Candy					Peas				
Beer					Corn				
Liquor					Fast foods				
Potatoes					Pizza				
Fruit					Fish (fried)				
Salads					Chicken (fried)				
Green vegetables					Burgers				
Eat Breakfast	Y	N			French fries				
Eat Lunch	Y	N			Eat At Night	Y	N		
Eat Dinner	Y	N			Eat Between Meals	Y	N		

If client is under 18 years of age, parent or legal guardian please sign authorization for treatment.

DATE _____ CLIENT'S SIGNATURE _____

I have read the above information and have stated all my known medical conditions. I understand that the practitioner does not diagnose illness, disease or any other physical or mental disorder. I take it upon myself to update my practitioner regarding any changes in my condition. I understand that my practitioner is not a medical doctor.

I understand that Elements of Health, Inc. requires a 24-hour advance notification prior to any cancellation or schedule changes as a courtesy to its staff and clients.

Signed _____ Date _____

INFORMED CONSENT

Signing this form indicates that you are voluntarily and knowingly undergoing a procedure referred to by FDA as electro dermal screening. It is a form of modern bio energetic science. The technique was discovered by Dr. Voll, M.D. of Germany around 1926. EDS is currently available in England, South America, China, Canada, Australia, and the United States.

The procedure is totally non-invasive (the skin is not punctured). This procedure includes the application of an electronic probe of five volts to measure skin resistance at selected acupuncture sites located on the hands and feet. It will then be determined as to which natural substances will be needed to re-establish proper balance to the body's chemistry.

Because the procedure involves only the measurement of changes in the meridian flow with a sensitive meter, it is completely safe. The only sensation that is usually felt is just the pressure of the electronic probe as it is pushed against the skin. The use of the computer makes the procedure extremely fast. Please note that the equipment utilized is non-diagnostic in nature.

At no time will there be any implied and or stated indication for any client to discontinue taking any medication as prescribed by his or her physician. At no time will there be any implied and or stated indication to any client to discontinue care under the direction of any other physician. This procedure is approved by the FDA for investigative use only at this time and is not intended, implied, or stated to take the place of any conventional medical test and or diagnostic procedure.

At no time can this office guarantee implied and or stated resolution, but it has been found that complete client compliance to the natural health care recommendation usually results in greater and more consistent changes towards better health. If you, the client, wish to decline participation in this program, you may do so at any time. This office reserves the right to dismiss any client at any time due to poor compliance to the program.

I have fully read and understand the above information, the statements of informed consent, my responsibilities and rights, and hereby consent to the participation in the electro dermal screening procedure. For the purpose of advancing medical knowledge, I consent to the discreet use of clinical reports and results of my case for study, research, and scientific purposes.

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

PART 2: INFORMED CONSENT

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term “DRUG” is defined to mean: “Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”

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Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of food in the patient’s diet in order to supply good nutrition, supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above:

Signature: _____ Date: _____

Signature of Parent/Guardian _____ Date: _____

ELEMENTS OF HEALTH, INC

DR. KATHLEEN JONES D.C., N.D.
7870 OLENTANGY RIVER RD, SUITE 208
COLUMBUS, OH 43235
PHONE: 614-888-4372

TO ALL NEW PATIENTS:

PLEASE NOTE THAT DUE TO HEALTH CODE REGULATIONS
THERE CAN BE **NO REFUNDS** ON HAIR, STOOL, URINE, AND
SALIVA TEST KITS.

THANK YOU,

DR. KATHLEEN JONES

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

PATIENT SIGNATURE _____ DATE _____

Elements of Health
7870 Olentangy River Rd, Suite 208
Columbus, OH 43235

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.

In the course of your care as a patient at Elements of Health we may use or disclose personal and health information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, your employer, managed care organization or attorney if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health information that may be of interest to you such as patient appreciation days, special events, holiday specials and birthday cards.

If you are not at home to receive an appointment reminder, a message may be left on your answering. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing healthcare services to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or any other appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive any treatment from us.

We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different format, please advise us in writing as to your preferences.

You have the right to inspect and or copy your health information for seven years from the date that the record was created, or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our policy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy policy may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. If you would like further information about our privacy policies and practices please contact:

Kathleen Jones, D.C., N.D.
7870 Olentangy River Rd, Suite 208
Columbus, OH 43235

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Print Please)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Represented (Print Please)	Signature	Date

Description of the authority to act on behalf of the patient: