vitality
CHIROPRACTIC

WELCOME!

Thank you for choosing Vitality! Are you ready for a healing approach like you've never experienced before? Our custom Chiropractic sessions will help guide you to discover the amazing wellness potential within you.

Our Healing and Wellness Approach

Healing and wellness are processes, not events, and we are not a "quick fix" practice. We strive to build a relationship with you as we assist you in achieving your overall health and wellness goals. Our holistic approach transforms your physical body's alignment and spirit to help achieve better balance.

Your Chiropractic Sessions:

Your experience starts with a pain control therapy or a fully customizable HydroMassage that gives you powerful, heated, deep-tissue relaxation. You will then receive your Chiropractic Adjustment using light touch and gentle instruments. We also incorporate Lifestyle Coaching and all the TLC that makes Vitality unique. Your sessions are never procedures done to you, but instead are creative healing experiences with you.

Payment & Insurance: You will be required to pay for your sessions at the time they are rendered. The new patient exam is $85 (Re-Exams - $30) and the session fee is $75. If your insurance company covers chiropractic care it is possible you may receive some reimbursement. We will assist you with that process by printing you a "Superbill," that you send in. Vitality is not a participating provider for any insurance company.

Initial _____

Diagnosis: We do not diagnose or treat any symptom, disease, or condition. If you have questions about naming or treating symptoms, we encourage you to consult with a medical doctor. It is important to understand that we do not imply that any particular session or series of sessions will "cure" any symptom, disease, or condition.

Initial _____

HydroMassage: Anyone experiencing one or more of the following conditions, or have a condition that heat or massage would have an adverse effect should get physician approval prior to use: Heart or circulatory problems, inflammatory conditions such as phlebitis, varicose veins or thrombosis, swollen joints, acute inflammations, severe bruising, skin infections, contagious diseases, a high temperature, pain radiating to the arms or legs when the back is massaged, any other conditions in which heat or massage would be harmful. Please use caution after use of HydroMassage equipment. Some users report sensations of dizziness or lightheadedness following their HydroMassage session. I acknowledge that I have read the above contraindications, and that my use of the HydroMassage equipment is completely voluntary. I hold JTL Enterprises Inc. / HydroMassage, and Vitality Chiropractic completely harmless for any injury resulting from the use of the HydroMassage equipment.

Initial _____

24 Hour Scheduling Policy: Missed, Late or Rescheduled appointments, unless emergency or weather related, must be within a 24-hour notice period, or you will be subject to a $25 fee.

Initial _____

_____

Signature Date

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DATE / /

NAME AGE DOB / /

ADDRESS

CITY STATE ZIP

CONTACT NUMBERS M( ) HM( ) WK( )

EMAIL SSN - -

Who may we thank for referring you to Vitality?

ASSESSMENTS

The following sections will assess where you are from a holistic approach, to determine your baseline. Section 1 outlines your overall physical assessment. Section 2 gives you space to address specific health issue(s), Section 3 overviews your body-mind-spirit states, and Section 4 provides us with information about your personal goals and expectations.

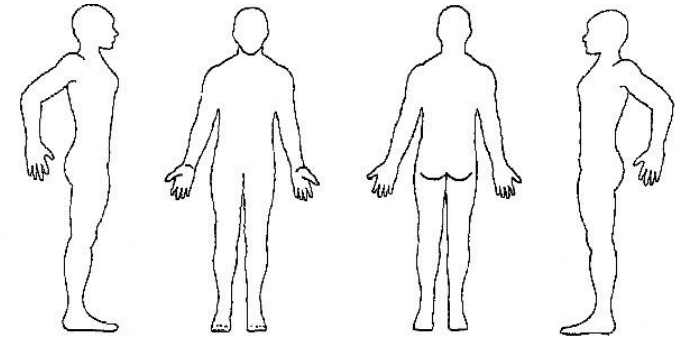
Section 1: Physical Assessment: Please (x) if you are experiencing any conditions Currently(C) and/or in the Past(P)

Condition(s)	C	P	Condition(s)	C	P	Condition(s)	C	P
Vehicle Accident (s)			Numb/Tingly Leg			Poor Sleep		
Major Slips/Falls			Numb/Tingly Arm			Heart Disease		
Sports Participation			Irregular Menses			Constipation		
Neck Pain/Stiffness			Urinary Problems			Heartburn		
Sit/Stand long hours			Loss of Balance			Upset Stomach		
Repetitive Motions			Loss of Smell/Taste			Hot Flashes		
Surgery (s)			Ringing in Ears			Chest Pain		
Broken Bone (s)			High Blood Pressure			Headache/ Migraine		
Back Pain			Fainting			Dizziness		
Diarrhea			Allergies			Fatigue		
Cold Hands			Cold Feet			Cancer		

List any other issues and/or comment on any of the above: (ex, Dates/type of surgeries, accidents, what allergic to, etc.)

List any medications, vitamins, supplements, etc. and why you use them:

Section 2: Specific Health Issue: If you have more than one health issue to address, please print a separate page for each issue.

PLEASE FILL IN WITH DETAIL	FOR OFFICE USE ONLY
What is the health issue?	
When did it start?_____/_____/_____ M D YYYY Is this the first time you've experienced it? If no, when?	
What do you do that makes it feel better?	
What do you do that makes it feel worse?	
Are you feeling any sensations? ☐Sharp ☐Dull ☐Numb ☐Tingling ☐Stabbing ☐Tightness ☐Other _____	
Rate your pain on a 1-10 scale. '0' is no pain: /10	
Are you experiencing anything radiating? (circle) Right arm Right leg Left arm Left leg Other: _____	
Where on your body are you experiencing your issue? (circle)  Right Front Back Left	
Describe your issue: ☐ Staying Same ☐ Getting Better ☐ Getting Worse	
How often are you experiencing this health issue? ☐ Intermittently (0-25%) ☐ Occasionally (26-50%) ☐ Frequently (51-75%) ☐ Constantly (76-100%)	
Does your issue interfere with any of the following? ☐ Sleep ☐ Walking ☐ Sitting ☐ Standing ☐ Playing	
List any other solutions and/or practitioners utilized for this issue:	
Height:____'_____" Weight: _____lbs. Shoe size: _____	

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Section 3: Body-Mind-Spirit State

BODY STATE	4	3	2	1	0	FOR OFFICE USE ONLY
Do you eat healthy and/or organic foods?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you drink water? How much? _____	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you exercise? How consistently?_____	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you stretch? How consistently?_____	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you receive massage or body work? How consistently?_____	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you detox and/or cleanse? How consistently?_____	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you listen to and understand your body signals?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
					BODY _____ /28	
MIND STATE	**4**	**3**	**2**	**1**	**0**	**FOR OFFICE USE ONLY**
Are you mindful of yourself? (respect, listen & love self)	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you allow time for yourself? (playtime, downtime, self-care etc.)	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you use positive self-talk?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you have a clear, centered and relaxed mind before you sleep?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you process and feel balanced in your emotions?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you listen to your instincts?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
					MIND _____/24	
SPIRIT STATE	**4**	**3**	**2**	**1**	**0**	**FOR OFFICE USE ONLY**
Do you breathe or meditate?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you take time to connect with nature and/or animals?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you take time to connect with other humans?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you feel in control of your life?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
Do you take time to relax?	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	
					SPIRIT _____/20	
					BODY-MIND-SPIRIT TOTAL _____/72	

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Section 4: About Your Expectations:

ABOUT YOU	FOR OFFICE USE ONLY
What is your occupation or life work?	
Do you enjoy where you live and why?	
Do you have a family or social life that brings you joy?	
What recreational activities do you do?	
What do you love about your life?	
Where are you resisting in your life?	
EXPECTATIONS	**FOR OFFICE USE ONLY**
Why did you choose Vitality?	
What would your short-term expectations look or feel like for you?	
What would your long-term expectations look or feel like for you?	
Do you have any questions on our Chiropractic approach? (HydroMassage, Chiropractic Care, and/or Lifestyle Coaching)	
Do you have any other lifestyle goals?	
Is there anything else you would like Vitality to know about you?	

If you are ready to work together to discover the amazing wellness potential within you…
then you are in the right place! I look forward to connecting with you! ~ Dr. Kent Sifford

Vitality Chiropractic
750 Sheridan Lake Rd
Rapid City, South Dakota 57702
PH: 605-716-4455

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Vitality Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you, and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date