WELCOME!

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

Our Healing and Wellness Approach

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

Your Child's Chiropractic Sessions:

You and your child's experience with Vitality starts with a pain control therapy or a fully customizable HydroMassage to relax the body and mind. You will then be escorted with your child into the adjusting room for your child to receive the Chiropractic Adjustment using light touch and gentle instruments. We also incorporate Lifestyle Coaching and all the TLC that makes Vitality unique. Please allow 30 minutes for each session. The sessions are never procedures done *to* the child, but instead are creative healing experiences *with* your child. The parent/guardian is always encouraged to observe the sessions.

Payment & Insurance: You will be required to pay for your sessions at the time they are rendered. The new patient exam is $50 (age 10 and over) or $30 (under age 10) and the session fee is $75 for children age 5 and older, $50 for children under age 5. 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.

Parent/Guardian 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.

Parent/Guardian 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.

Parent/Guardian 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.

Parent/Guardian Initial ____________

Parent/Guardian Signature ______________________________ Date

DATE ______ / ______ / ______

CHILD'S NAME ______ AGE ______ DOB ______ / ______ / ______ SEX M / F

ADDRESS ______ CITY ______ STATE ______ ZIP ______

PARENT/GUARDIAN #1 ______ RELATIONSHIP ______

PHONE M( ) ______ HM( ) ______ WK( ) ______

EMAIL ______

ADDRESS ☐ SAME ______ CITY ______ STATE ______ ZIP ______

PARENT/GUARDIAN #2 ______ RELATIONSHIP ______

M( ) ______ HM( ) ______ WK( ) ______

EMAIL ______

ADDRESS ☐ SAME ______ CITY ______ STATE ______ ZIP ______

Who may we thank for referring you to Vitality? ______

CONSENT TO CARE FOR A MINOR

I (we) being the parent/guardian(s) of the above named minor do hereby authorize, request, and direct Vitality Chiropractic, Dr. Kent Sifford, and staff to perform examinations and any care that in their judgment is recommended while the child is under the care of Vitality until legal age.

______

Parent/Guardian Signature ______ Date

ASSESSMENTS

The following sections will assess where the child is from a holistic approach, to determine the child's baseline. Please fill out comments for any that need further explanation to the best of your knowledge.

Section 1: Pregnancy: Please (x) if any of these scenarios applied to the child's birth mother during pregnancy term.

__ Excessive Wt Gain/Loss
__ Surgery
__ Recreational Drugs
__ Alcohol Intake
__ Premature Contractions

__ Caffeine (any type)
__ Illnesses
__ Hospitalizations
__ Immunizations
__ Bleeding
__ Smoking

__ Back Pain
__ Complications
__ Medications
__ Allergic Reactions
__ Vitamins/Minerals

__ Full-term Pregnancy
__ Prenatal Classes
__ Chiropractic Care
__ Good Attitude

Please comment on any of the (x) above or on anything not listed:

____

____

Section 2: Labor, Delivery and Birth: Please (x) any that apply to child.

__ Birthing Center
__ Home Birth
__ Premature Birth
__ Cesarean Birth
__ Vaginal Birth

__ Medications
__ Forceps/Suction
__ Circumcision
__ Silver Nitrate
__ Vitamin K

__ Excessive Crying
__ Unusual Coloring
__ 12+ hours labor
__ Complications
__ Choking

__ Nursing Problems
__ Breast Milk
__ Formula
__ Sleeping Difficulty
__ Surgery

Please comment on any of the (x) above or on anything not listed:

____

____

Section 3: Health Profile: Please (x) any that apply to child.

__ Childhood Illness
__ Auto Accidents
__ Drug Reactions
__ Serious Childhood Falls
__ Ear Problems
__ Sports
__ Allergies
__ Caffeine

__ Vaccinations
__ Child Unconscious
__ Back Pain
__ Secondhand Smoke
__ Skin Problems
__ Surgeries
__ Diarrhea
__ Artificial Sugar

__ Vaccine Reactions
__ Urinary Problems
__ Antibiotics
__ Extremity Pain/Limping
__ Sleeping Problems
__ Bed Wetting
__ Constipation
__ Heavy Backpack

__ ADD Symptoms
__ Inhalers
__ Emotional Traumas
__ Abnormal Stool
__ Headaches
__ Eye Problems
__ Other

Please comment on any of the (x) above or on anything not listed:

____

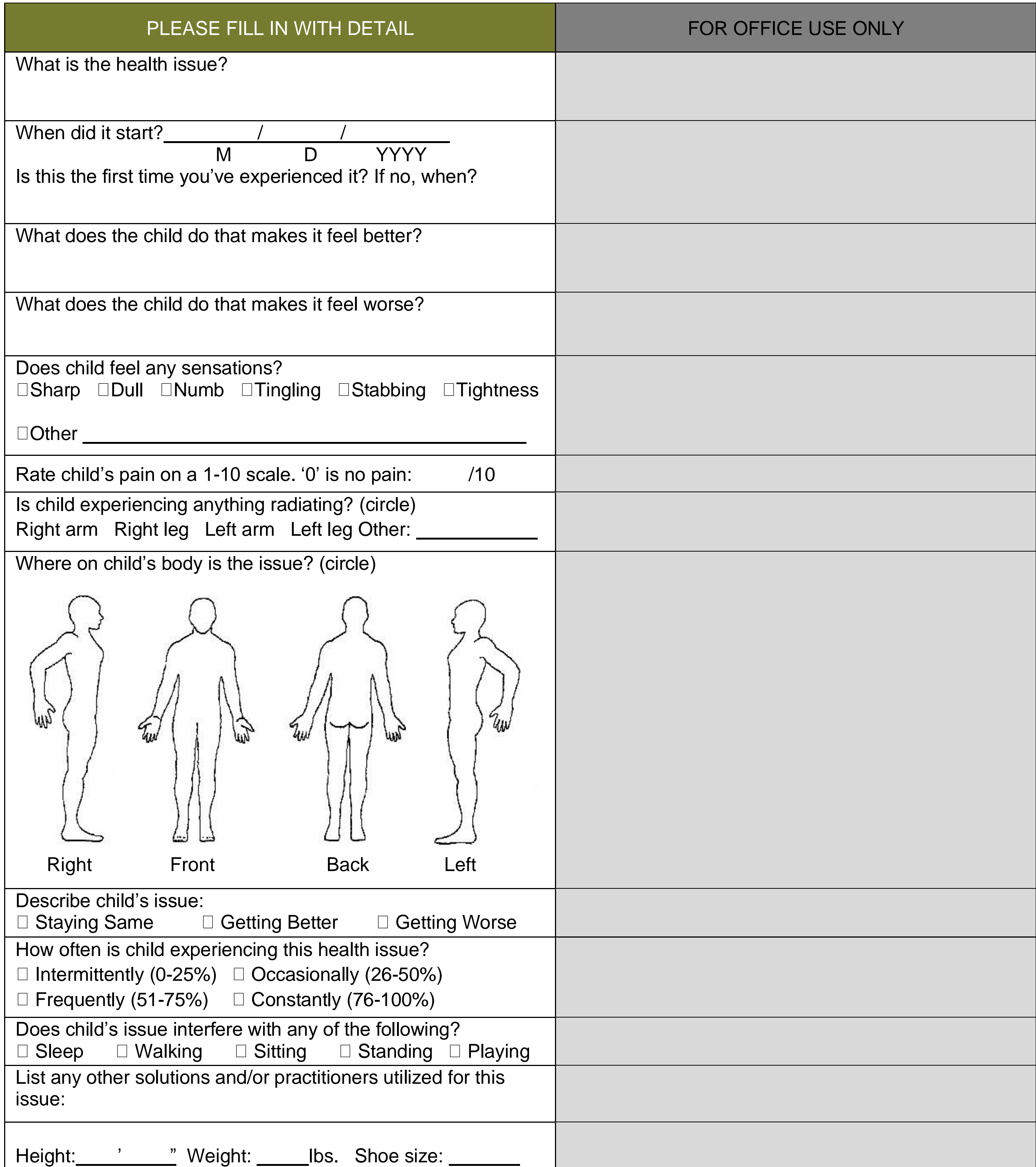
____

Current Medications & Purpose: ____

Any Medical Diagnoses: ____

vitality
CHIROPRACTIC

Section 4: Specific Health Issue: Address the child's specific health issue here if applicable.



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 does the child do that makes it feel better?	
What does the child do that makes it feel worse?	
Does child feel any sensations? ☐Sharp ☐Dull ☐Numb ☐Tingling ☐Stabbing ☐Tightness ☐Other ____________________	
Rate child's pain on a 1-10 scale. '0' is no pain: /10	
Is child experiencing anything radiating? (circle) Right arm Right leg Left arm Left leg Other: ________	
Where on child's body is the issue? (circle) Right Front Back Left	
Describe child's issue: ☐ Staying Same ☐ Getting Better ☐ Getting Worse	
How often is child experiencing this health issue? ☐ Intermittently (0-25%) ☐ Occasionally (26-50%) ☐ Frequently (51-75%) ☐ Constantly (76-100%)	
Does child's 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: ______	

Section 5: Expectations: Goals and expectations for your child's journey at Vitality.

EXPECTATIONS	FOR OFFICE USE ONLY
Why did you choose Vitality?	
What would your short-term expectations look or feel like for the child?	
What would your long-term expectations look or feel like for the child?	
Do you have any questions on our Chiropractic approach? (HydroMassage, Chiropractic Care, and/or Lifestyle Coaching)	
Do you have any other lifestyle goals for the child?	
Is there anything else you would like Vitality to know about the child?	

If you are ready to work together to discover the amazing wellness potential within your child…
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