

WELCOME TO VITALITY CHIROPRACTIC

You are about to be empowered to a life of optimal health & vitality. Our office is on the cutting edge of health care. At Vitality Chiropractic you will be provided excellent health care and your experience of getting healthy will be awesome. Before you begin this experience, sit back, relax and begin learning exactly why Vitality Chiropractic sets itself above the others.

We specialize in assisting our practice members to achieve their highest level of health through our spinal, neurological and postural wellness programs. Our approach is very unique and advanced compared to other health care offices. This allows our practice members to achieve far superior results compared to most other health care systems. This office is not like your typical Chiropractic, medical or other health care office. It was designed that way for a reason, a very important reason, **YOU**. In the day of the Internet, computerized secretaries, and HMO/PPO monopolies, it is difficult to find someone who really cares and will give you a **Service Oriented Experience**.

How many times have you spent good hard-earned money for something and just felt like saying, "Why did I bother?" The value of the product was drastically diminished when the service getting that product was terrible.

I want you to know that at Vitality Chiropractic it is my personal goal to give you the best Chiropractic care, while providing excellent service, and an experience that makes you say, "**WOW!**"

- From the state of the art computerized nerve testing to the soothing fountain
- From the ball chairs right out of The Jetson's cartoon to the state of the art wobble chairs to rejuvenate spinal discs
- Finally, from the highly energetic open adjusting room to the most energizing chiropractic technique, **EVERYTHING** in this office has a purpose.

The purpose of the office setup is to teach you how to find the health you have lost and how to keep it once you have found it, all while giving you the "WOW" experience.

You will not find an institutionalized, stuffy, cold, or quiet white-coated doctor's office with staff that seems to only focus on their paycheck. You will find an office entirely the opposite whose dedication is to you, where children are highly visible, the energy is tremendous, where my team is comfortable and really loves what they do. You can call me Coach, Dr. Rob or Dr. Anderson (just as long as you remember my name so you can tell all your friends.)

I do want you to know that I take Chiropractic very seriously, so much so in fact, Chiropractic is not what I do, but what I am.

If this is what you are looking for, continue taking the next few steps toward Optimal Health and fill out the paperwork following this letter. Thank you in advance for your commitment to your health. I will visit with you soon.

Yours In Health,

Dr. Rob Anderson

PRACTICE MEMBER INFORMATION

Date: _____

Name: _____ Home Phone: _____ Cell Phone: _____

Age: _____ DOB: _____ M F Marital Status: S M D W E-mail address: _____

SS#: _____ Address: _____ City: _____ Zip: _____

Occupation: _____ Employer: _____ Spouses Name: _____

Spouses Employer: _____ Children's Names/Ages: _____

Do you notice poor posture in your children or spouse? Yes No Who referred you? _____

Have you ever received chiropractic care? Yes No Do you know your posture leads to your health? Yes No

What have you heard about Chiropractic? _____

Do you know that your posture determines your health? Yes No Are you aware of any poor posture habits? Yes No

The most common postural weakness is Forward Head Syndrome. This happens when the head and neck start to bend forward and progressively move downward weakening the whole body. Even less severe forms of this posture can cause many adverse effects on your overall health.

Have you ever been told or feel like you carry your head forward? Yes No

ADDRESSING THE ISSUE THAT BROUGHT YOU TO US

If you have no complaints but are here for wellness services, please skip to the next section.

Please describe the complaint that brought you to our office: _____

Is your pain, Sharp Dull Numb Throbbing Travels Does it affect you Constantly or Occasionally

Was there a specific incident, accident, or condition that you think could have caused this problem? Yes No

If yes, what happened? _____

Since the problem started, is it About the same Getting better Getting worse When did it start? _____

Have you had this problem more than 2 times? Yes No If yes, how often? _____

What makes it worse? _____

It interferes with: Hobbies or Sports Work (responsibilities, tasks, duties) Social Time (kids, spouse/friends)

What have you tried to rid yourself of this problem? Ice/Heat Stretching/Exercise Vitamins Medications Mineral Ice

Changed Diet Aspirin/Tylenol etc. Stress Reduction

Other doctors seen for this problem including name, diagnosis and your response to their care:

Chiropractor _____

Medical Doctor _____

Other _____

On a scale of 1-10, rate your commitment to getting rid of this problem. _____

YOUR HEALTH LIFESTYLE

YES NO

Do you exercise? What & How often/week? YES NO _____

Do you buy pure water? How much do you use? YES NO _____

Do you use vitamins or supplements? What? YES NO _____

On a scale of 1-10 describe your stress. (0=none, 10=extreme) Occupational _____ Personal _____

On a scale of Poor, Good, Excellent describe your: Diet _____ Sleep _____

How committed are you to living in Optimal Health? _____

REVIEW OF TRAUMAS AND STRESSORS

Throughout life, events occur which damage the expression of health causing alterations of posture, function or neurological health. This case history will uncover layers of damage that resulted in poor health.

	Yes	No	If Yes, please provide comments:
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen from a height over three feet?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had prolonged use of medicine?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you suffered any traumas or fractures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you drink coffee? How much?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do / did you smoke? Packs/day?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you drink alcohol? How much/week?	<input type="checkbox"/>	<input type="checkbox"/>	_____
List any medications you are taking, the reason and the doses:	_____		

HEALTH CONDITIONS

Abnormal postural habits or distortions cause kinks in vertebrae of the spine and are the result of trauma or stress to the body. When these vertebrae are twisted from their normal healthy position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These kinks in the spine are called Subluxations (sub-lux-a-shuns). It has been extensively documented that Subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted posture. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Neck (Cervical Spine):

Postural distortions from **Subluxations**, (causing **Forward Head Syndrome**), in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Have you experienced...?

- | | | | | | |
|------------------------------------|--|---|---|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Visual Problems | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in arms/hands |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Recurrent Colds/Flu | <input type="checkbox"/> Weak Grip | <input type="checkbox"/> Low Energy/Fatigue | <input type="checkbox"/> Hearing Disturbances | |
| <input type="checkbox"/> TMJ Pain | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Thyroid Conditions | | <input type="checkbox"/> Numbness/tingling in arms/hands | |

Upper and Middle Back (Thoracic Spine):

Postural distortions from **Subluxations**, (resulting from **Forward Head Syndrome**), in your upper and middle back will weaken the nerves to the heart, lungs, ribs, chest and upper digestive tract and affect these parts of your body. Do you experience...?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Recurrent lung infections/bronchitis | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain into your Ribs/Chest |
| <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Pain on deep inspiration/expiration | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Heart attacks/Angina | <input type="checkbox"/> Tired/Irritable when you haven't eaten | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tired/Irritable after eating | <input type="checkbox"/> Altered Liver Function | |

Lower Back (Lumbar Spine):

Postural distortions from **Subluxations** in the low back (resulting from **Forward Head Syndrome**), weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience...?

- | | | |
|--|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/feet | <input type="checkbox"/> Menstrual irregularities/cramping |
| <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infections |
| <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Coldness in your legs/feet | |

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits and risks.

Chiropractic is the science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of infirmity.

A **Vertebral Subluxation** is a disturbance to the nervous system caused by a misalignment or restriction of one or more of the 24 vertebra in the spinal column. This alteration of nerve function and interference to the transmission of mental impulses results in a lessening of the body's innate ability to express its maximum health potential.

An **Adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine, which can be performed by hand or by handheld instruments.

If during the course of a chiropractic spinal examination or spinal care, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

All health care procedures carry some risk. Many people report some mild soreness following their first adjustment. This is the body's natural reaction to a change, which is similar to lifting weights for the first time. Other risks include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries and fractures. Severe risks occur to 1/1,000,000 to 1/15,000,000 depending on the source utilized. Any valuable testing that can be performed in your case will be utilized to evaluate you.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. The benefits and risks of chiropractic care have been explained to me to my satisfaction. I understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I understand that I am responsible for all fees for services rendered and that all fees are payable when services are rendered unless special arrangements are made. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

(Print Name)

(Signature)

(Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of

have read and fully understand the above
Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Onset of last menstruation:_____

(Signature)

(Date)

Vitality Chiropractic, P.C. Rob Anderson, D.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4-15-2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time; such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up chiropractic supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services. We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, there will be a charge per item.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with the decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Service.

Contact: Rob Anderson, D.C. Phone: 303-346-7095 Fax: 303-346-7097 Address: 541 W. Highlands Ranch Parkway, Suite 104, Highlands Ranch, CO 80129

I hereby certify that I have received a copy of this Notice of Privacy Practices.

Signature

Date