THE VITALITY CENTER

WELCOME TO OUR FAMILY!

We know you have many options for your well-being, and truly embrace that you have chosen us to take care of you and any other of your family members. Our goal is to provide you with the best coordinated, highest quality care. To reach this goal our skilled team take a personalized approach to care by sitting down with you and discussing your needs and treatment.

Your health and overall wellness is our primary concern. Our team of integrated Practitioners cover many areas of your total health including: spinal decompression and chiropractic care, registered massage therapy, preventative care, diagnostic and genetic testing, nutrition and weight-loss, non-surgical medical spa treatments including laser hair removal, skin tightening, photofacial RF and Velashape.

The partnership we are about to embark on is one which we hope will renew your health and keep it that way for as long as possible. Our professional team will impart our skills and knowledge, and hope that in return you are responsible for your part in the treatment and healing process, and in sustaining what we achieve together. Health is a lifetime of work. We are here for you. Let's get started!

Together we hope to set goals and assist you in the amazing process of healing and total wellness.

As our gift to you for becoming a new patient at our clinic, we offer *a 15 minute complimentary consultation on genetic testing and/or nutrition, as well as a free 15 minute skin analysis with recommendations.* Please book these at your first appointment in conjunction with your follow-up visits.

Again, our sincerest thanks to you for choosing us. It is our pleasure to serve you and any other members of your family that may benefit from our outstanding care.

THE VITALITY CENTER TEAM

Patient Introduction

Personal History:

Your Name: _____
First Middle Last

Your Complete Address:

_____

_____

Telephone: Home:_____ Cell: _____

E-mail: _____

☐ Please check here if you want to receive updates and promotions
☐ Please check here if you would like auto-reminders for your appointments

Extended Health Care Provider : _____

Birth Date: Day: _____ Month: _____ Year: _____

Marital Status:_____

Occupation: _____

Employer: _____

Previous Chiropractor: _____ City: _____

Date of Last visit to this Chiropractor:_____

Reason for leaving:

_____

_____

Present MD: _____ City: _____

Referred to our Centre by:

_____

Adult Consultation History

Your Name: _____

Your Main Complaint: _____

Any other Complaints: _____

_____

How long have you suffered with this problem? _____

What have you tried to do to get rid of this problem that DID NOT work? _____

_____

_____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

Does handling this problem cause stress for you? _____

_____

What do you do that makes this problem worse? _____

_____

How many years older does this make you feel? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

What gives you some temporary relief? _____

What is the pattern of this problem? Constant ___, Intermittent ___, Occasional ___ Cyclic ___

What is the effect it has on your body functions? _____

How did it start? _____

Are you on any type of medication?_____

Please list all: _____

_____

Could your problem have been caused by an injury at work?_____

If yes, please give us the details: _____

_____

_____

Have you been involved in an auto accident? _____

Date of accident: _____

Any difficulties from this?_____

_____

Do you have any children? _____

Do they have any health problems that you are aware of? _____

_____

Is there any other information you would like us to know?_____

_____

_____

_____

_____

_____

<u>For Women Only</u>

Date of your last menstrual period: _____

Are using any means of contraception? _____

Do you experience severe cramping with your menstrual period? _____

Do you suffer from PMS? _____

FAMILY HEALTH HISTORY

Patient Name: _____ Date: _____

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Siblings	Children	Self
	Age	Age	Age	Age Age	Age Age	
ADHD						
Allergies						
Arthritis						
Asthma						
Autism						
Back Trouble						
Bed Wetting						
Bursitis						
Cancer						
Chest Pain						
Colic						
Constipation						
Crohn's Disease						
Depression						
Diabetes						
Diarrhea						
Disc Problems						
Down's Syndrome						
Ear Infection						
Emotional Issues						
Emphysema						
Epilepsy						
Headaches						
Migraines						
Heartburn						
Heart Trouble						
High Blood Press						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney Trouble						
Neck Pain						
Neuritis						
Nervousness						
Pinched Nerve						
Scoliosis						
Sinus Trouble						

Signature of Patient:_____ Date:_____