Hello and thank you for inquiring about Care at The Vitality Center!

Enclosed are some forms for you to complete and bring to your initial visit. This information will help us to become better acquainted with you so that we might

better support you and your goals for care.

The natural state of living things is **ease**. Each of us is capable of finding our way back from physical, chemical, emotional and mental overloads, to our natural state. This journey of returning to wellness is called healing. And it is a journey! Our purpose is to facilitate your healing process by creating more space in your spine and nervous system. This will enable you to *feel* more, your body to reorganize and become more efficient, and allow you to make better choices for your overall well being. We do this with gentle, honoring, specific contacts along the spine as well as coaching, and somatic body work.

Changes you can expect over time:

- Stronger posture and spines that are softer and more supple.
- Improved overall physical vitality: more energy, greater flexibility, reduced chronic pain, fewer colds and headaches.
- Greater ability to cope with stress in the areas of health, family, relationships and work.
- Improved emotional and psychological well-being.
- Improved communication and greater capacity for interrelation connection/ intimacy.
- Overall quality of life improvement.

We hope this will inspire you as much as it does us. We look forward to meeting you, and to a deep healing journey together.

In Wellness,

Dr. Jane Arzt, D.C.
and The Vitality Team

5901 Christie Avenue, Suite 105, Emeryville, CA 94608
Telephone 510 654 1480 Email Wellness@NetworkVitalityCenter.com

DIRECTIONS TO:

THE VITALITY CENTER

5901 CHRISTIE Avenue, SUITE 105

FROM THE FREEWAY:

Highway Exit off 580/80 (Eastshore Freeway) is Powell Street/ Emeryville. Head east on Powell Street. At the next intersection take a LEFT onto Christie Avenue. We are in the five-story building on the left behind the Fedex/Kinko's that you will see as you turn onto Christie. If you look up, you will see '5901'. Make a left into the parking lot at 59th Street. The entrance to our building faces the bay or the freeway and is in the back of the building. We are located on the 1st floor, Suite 105 at the end of the hall.

FROM STANFORD AVENUE:

Take Stanford Avenue towards Emeryville – it turns into Powell Street. Follow Powell over the bridge that crosses the train tracks. At Christie Avenue, take a RIGHT. We are in the five-story building behind the Fedex/Kinko's that you will see as you turn onto Christie. If you look up, you will see '5901'. Make a left into the parking lot at 59th Street. The entrance to our building faces the bay or the freeway and is in the back of the building. We are located on the 1st floor, Suite 105 at the end of the hall.

PHONE - 510 654 1480

THE VITALITY CENTER
enhancing health, community, & joy!

Comprehensive Health Profile

Date: ___ / ___ / ___

Name: _____ Occupation:_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (___)___-___ Business Phone: (___)___-___ Cell Phone: (___)___-___
Email: _____ Date of Birth: __ /__ /__ Height: ___' ___"
Marital Status: S M W D Number of Children:_____
Health Insurance: _____ Policy No: _____ Group No: _____
Who referred you to our office and the professional services we offer? _____
_____

Have you received any type of chiropractic care in the past? ☐Yes ☐No
Were you pleased with their care? ☐Yes ☐No If yes, why did you discontinue your chiropractic care?
_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

1) Do you currently have any health concerns? ☐Yes ☐No Please Describe: _____
_____
_____
_____

2) Please grade and circle the level to which this health concern(s) affects the following aspects of your functioning/quality of life.

0 – It does not seem to affect me. 1 – It seems to slightly affect me.
2 – It seems to moderately affect me. 3 – It seems to drastically affect me.

Affect on Work	0123	Affect on Recreation/Play	0123
Affect on Rest/Sleep	0123	Affect on Social Life	0123
Affect on Walking	0123	Affect on Sitting	0123
Affect on Exercise	0123	Affect on Eating	0123
Affect on Love Life	0123		

3) Have you done anything or sought treatment for this situation or concern? ☐Yes ☐No
If yes,what were told? _____
_____
4) What was done? _____
Did it seem to work? _____
5) What was different about YOU, after treatment? _____
_____
6) What was different about your CONDITION or SYMPTOM after treatment? _____
_____
7) Why do you think this has happened, or continues to happen, to you? _____
_____
Do you think this is the sole cause? ☐Yes ☐No If No, what else is involved? _____
_____

8) Which of the following BEST describes your current condition? (Please choose only ONE)

☐ I feel helpless; nothing works.
☐ I don't like what I am feeling, and I hope you can fix it.
☐ I feel this is a pattern that has happened to me before; it is back again.
☐ I feel there is a message my body is giving me.
☐ I am looking for assistance in becoming healthier so I can move past my health concern.
☐ I realize my condition may be a necessary experience in getting to the real problem.
☐ I don't know how I feel. I am too preoccupied with my present condition.
☐ I am looking for something to help me enhance my quality of life and wellness.

9) What do you hope to receive from Network Care in this office? _____
_____

OVERALL STRESS SURVEY

Please grade your Past/Current Life Stresses using the following scale:
0 - No awareness of stress 1 - Slightly stressful . 2 - Moderately stressful 3 - Extremely stressful

Overall Physical Stress/Trauma: 0 1 2 3
(includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.)

Overall Emotional/Mental Stress: 0 1 2 3
(includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships, etc.)

Overall Chemical Stress: 0 1 2 3
(includes: prescription drugs, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, over-the counter medications, etc.)

PHYSICAL HISTORY

BIRTH STRESS: Information about your birth history:

1) Did your mother have a difficult pregnancy with you? ☐Yes ☐No
2) Did she have any falls, accidents or physical injuries during pregnancy? ☐Yes ☐No
3) Was your birth traumatic? ☐Yes ☐No
4) Was your birth: Drug induced ☐Yes ☐No "C" Section ☐Yes ☐No Prolonged ☐Yes ☐No
Forceps or Suction ☐Yes ☐No Natural ☐Yes ☐No Breech ☐Yes ☐
Cord around Neck ☐Yes ☐No Other: _____
5) Describe any other physical or mechanical stress to your mother or you as labor progressed, delivery progressed, or as a newborn:_____

GENERAL PHYSICAL TRAUMA:

6) Were you ever knocked unconscious? ☐Yes ☐No If Yes, how/when? _____
_____
7) Have you ever broken any bones? ☐Yes ☐No If Yes, which one(s)?_____
_____
8) Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine?
Yes ☐No If Yes,how/when?_____

9) Have you ever injured your head, neck, back or hips? ☐Yes ☐No If Yes, how/when?
_____

10) Have you served in the military? ☐Yes ☐No If Yes, were you involved in combat? Yes ☐No
Details: _____
11) On average, how many hours per day do you participate in the following?
__Sitting __Standing __Desk Work __Phone Work __Computer Work
__Driving __Manual Labor __Lifting Heavy Objects __Stooping/Bending/Kneeling

SPORTS OR LEISURE:

12) Were you, or are you active in any sport(s)? Yes ☐No If Yes, which one(s)?
_____

13) Have you been hurt in any of these activities? Yes ☐No If Yes, when/where?
_____

AUTOMOBILE ACCIDENTS:

14) Have you, (even as a passenger, even if you do not think you were hurt), been involved in a car accident, or near collision? Please list approximate dates and severity (Mild, Moderate, Extreme).
Automobile: _____
Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____
_____

MEDICAL TREATMENT:

15) Have you ever been hospitalized? ☐Yes ☐No If Yes, what was done? _____
_____

16) Have you had surgery? ☐Yes ☐No If Yes, what was done? _____
_____

17) Do you have all of your body parts? ☐Yes ☐No If No, please describe: _____
_____

18) Have you ever had: ☐Spinal Tap ☐Spinal Injections ☐Physiotherapy ☐Neck Collar ☐Spinal Brace ☐Traction ☐Heel Lift ☐X-Ray Treatments ☐Corrective Shoes or Bars ☐Extensive Diagnostic X-Rays ☐Acupuncture ☐Chemotherapy ☐Transfusion ☐Body Part in a Cast or Immobilized?

CHEMICAL HISTORY

BIRTH STRESS:

1) Was your mother regularly taking any drug immediately prior to, or during her pregnancy with you? Yes ☐No IfYes,pleaseexplain_____

2) Did she use ☐Alcohol Smoking ☐Other: _____ 3) Was her labor chemically induced or altered? Yes No
4) During delivery, was your mother?
Conscious Semi-Conscious Unconscious Under Spinal Anesthesia
5) Any other chemical stresses that your mother may have been subject to during pregnancy, labor, or delivery? _____

GENERAL CHEMICAL TRAUMA:

6) Are you now taking any drug(s) (prescription or over-the-counter) regularly? ☐Yes ☐No
If Yes, please list drug(s), when prescribed and reasons for taking them: _____
_____

7) Were you previously taking any medication regularly? ☐Yes ☐No If Yes, which ones / how long?_____
_____

8) Do you now, or in the past, have a history of alcohol and/or drug abuse? ☐Yes ☐No
If Yes, please describe: _____

9) Do you, or did you, work with any chemical, fume, dust, powder, etc. for prolonged periods? ☐Yes ☐No If Yes, please describe_____

10) Please indicate how much of the following products you consume:
Alcohol: __Drinks/Week Coffee: __Cups/Day Tobacco: __Cigarettes/Day
Soda: __/Day Artificial Sweeteners ☐Yes ☐No If yes, which type:_____

EMOTIONAL HISTORY

BIRTH STRESS:

1) My birth was: ☐At Home ☐In a Birthing Center ☐In a Hospital ☐Other

2) Were you incubated or isolated after birth? ☐Yes ☐No

3) Were you: ☐Bottle Fed Formula ☐Bottle Fed Mothers Milk
☐Nursed - How Long? ____ ☐Nursed and Bottle Fed?

GENERAL EMOTIONAL TRAUMA:

4) For each of the following potential spinal stresses, indicate the severity either past or present:

Potential Spinal Stress/Tension Sources	PAST	PRESENT
Childhood Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
School Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Family Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Personal Relationships	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Stress of Being Sick	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Work Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Stress of Commuting	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Change in Lifestyle	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Change in Vocation	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc.)	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme

YOUR SPECIFIC NEEDS AND HOPES FOR CARE IN THIS OFFICE?

1) In a published study of Health and Wellness benefits for patients under Network Care (conducted at UC Irvine Medical School), patients reported an overall improvement in all of the categories listed below. How do you hope to benefit from care in this office?

A) Very important to me B) Important to me C) Not so important to me D) Does not apply

a) ___ Improvement of my Physical Symptoms.
b) ___ Improvement of Emotional/Mental Symptoms.
c) ___ Improvement of my Ability to React or Respond to Stress.
d) ___ Improvement in Enjoyment of Life and the Ability to make Healthier, more Constructive Choices.
e) ___ Overall improvement in Quality of Life.

2) Is there anything else you may wish to share which may help me better understand you, your history, or your professional and personal needs which have not been discussed in this profile? _____
_____

3) What would motivate you to tell others about the care you receive in this office and encourage others to get under Network Care? _____
_____

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1. What patterns keep circulating in your life? How do you feel stuck?

_____
_____

2. What crossroads are you currently at? What must change in your life?

_____
_____

3. If we had a magic wand and could make that change happen, what would be different about your life? (Impact on others?)

_____
_____

4. What will your life be like in 3 years if you do not make this change? (Impact on others?)

_____
_____

5. What are you most passionate about?

_____
_____

6. What positive emotional states do you experience regularly?

_____
_____

7. What negative emotional states do you experience regularly?

_____
_____

8. What emotions do you need to feel more of? (Especially to support the change listed above)

_____
_____

Name _____Date_____
Signature_____

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Consent to Treat Form

I hereby request and consent to receiving spinal care, including wellness education, in this office by a chiropractor(s) who provides Network Spinal Analysis (NSA) Care, a low force approach which has unique outcomes and clinical results. This practitioner(s) chooses to practice NSA, as (s)he is professionally and personally confident in regard to the safety and effectiveness of this form of care.

This office provides care in accordance with the *Council on Chiropractic Practice Guidelines* and the *Canon of Ethics of the Association for Network Care*, and my doctor(s) has been trained in traditional chiropractic care and certified in the procedures of NSA.

The purpose of this consent form is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

NSA does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. **Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.**

NSA consists of gentle touch contacts along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training. There is a body of research characterizing NSA care and documenting its unique and significant wellness benefits. I understand I may obtain copies of published research articles and/or abstracts in this office.

I am aware that I will be receiving gentle touch Network adjustments, also called entrainments. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension and case patterns. At regular intervals, following commencement of care, re-evaluations will be performed. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractor(s) will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and to re-organize my spine.

NSA is advanced through a series of Levels of Care. Each Level of Care involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with greater spinal stability, redistribution of energy, and transfer in internal information, are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I also understand that, in addition to NSA care and wellness education, my practitioner(s) may perform additional examinations or assessments and offer health/spinal care or advice that is consistent with my individual needs.

Please Read and Sign the Following:

It has been explained to my satisfaction, and I understand that the care offered in this office is not a form of, or a replacement for, the diagnosis and/or treatment of any symptom, disease, or malady and I am free to consult or see my medical physician at any time. Instead, NSA is a form of wellness care and self-education that empowers my connection with my body-mind and develops new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension, including those that are unique to NSA care.

It is common for people receiving NSA care to breathe more deeply and more fully, engaging the spine with their respiration, to spontaneously adapt postures that release or redistribute tension, to use stress, and to experience more of their inner life energy.

I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant changes. ***This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion and consciousness.***

Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and expression of life potential that I may never have had before. The internal wisdom within my own body is the true agent of healing, empowerment, coordination, inspiration, movement and joy.

I also understand that by their intent, various treatments may actually interfere with the functioning of the nervous system. These include drugs such as pain relievers, muscle relaxers, anti-inflammatory compounds and mood altering medications. These can often delay or prolong the healing process and it is my responsibility to keep my medical physician up to date regarding my changing needs.

I have read, or have had read to me, this CONSENT TO TREAT FORM and understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing process.

_____	_____
Printed name of Patient	Printed name of witness
_____	_____
Signature of Patient	Signature of witness
_____	_____
Date	Date

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Notice of Privacy Practices

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.

Patient healthcare information will be used as follows:

- Medical information, including health history, is collected from the patient upon initiation and subsequent visits, and is then stored in the patient's medical chart.
- Medical information will be used in the assessment of the patient's condition and the need for health care or referral purposes.
- Some of the medical information will be transferred to a computer program for the purposes of retrieval, storage, billing and payment purposes.
- Medical information will be disclosed to health and disability insurers for the purpose of payment or reimbursement of services.
- The Vitality Center will store the medical information contained in the medical record for a period of no less than six years (or longer if state law mandates a longer period of record keeping).

Patient healthcare information will be disclosed to the following:

- Other healthcare providers, for the purpose of referral, consultation or coordination of health care.
- Health care insurers.
- Business associates.
- Persons responsible for patient's health care, such as a parent or nurse.
- Billing organizations.
- Collection agencies.
- Law enforcement officials or agencies.
- Correctional institution.
- Public Health authorities.
- Research institutes.
- Family members.
- Workers compensation insurers or state agency, if applicable.

Patient healthcare information will be used and disclosed for the following purposes:

- Diagnosis, assessment, referral, and/or treatment.
- Payment by a third party, such as a health insurer.
- Day to day health care operations.
- Appointment reminder notices or messages.
- Recall notices or messages.

Patients have the following rights:

- To inspect and copy his/her protected health information.
- To place restrictions on certain uses and disclosures of his/her health information, whether or not The Vitality Center agrees with these restrictions.
- To amend his/her protected health information.
- To receive confidential communication of protected health information by an alternative method other than the stated means of communication.
- To a copy of the patient's Notice of Privacy Practices at any time.
- To an accounting of all uses and disclosure of his/her protected health information.
- To file a written complaint with The Vitality Center or the Secretary of the Department of Health and Human Services when appropriate.

_____	_____
Printed name of Patient	Printed name of witness
_____	_____
Signature of Patient	Signature of witness
_____	_____
Date	Date