Life Enhancement Clinic, P.C.
Patient Intake Forms

Name: ____ SSN#:_______________________

DOB:_______________ Age:_____ Gender: M F Married? Y N Referred by: ___________________

Address:____ City:_____________________ ZIP:_________

Home Phone:_______________ Work Phone:_______________ Cell Phone:_______________
OK to leave message? Yes No

E-mail Address:____________________ Occupation:_______________ Employer:____________________

May we add you to our e-mail newsletter? *(we do not sell or distribute your address, nor send spam)* Y N

Emergency Contact Info (Name/Number):____

Is the purpose of this appointment related to: □ Work □ Auto Accident □ Slip/Fall □ Sports Injury
□ Chronic Discomfort □ Other ______________________

Health Information

Present Health Concerns*: Please write your complaint as well as when the pain started, how the condition is changing, other providers you have seen and what you do for self treatment.*

Ex: Low Back Pain – started three weeks ago when I slipped on the ice and the pain is getting worse. I was treated and released in the ER and given pain medications. I also saw a physical therapist.

(1) ____

____

____

(2) ____

____

____

(3) ____

____

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PHYSICIAN USE ONLY

Surgeries/Hospitalizations/Injuries: *Please list all major events below with the year and outcome.*

Year	Surgery, Illness, Injury	Outcome

Medications and Nutritional Supplements *Please PRINT all medications and **allergies** as indicated below*

Medication	Dose/Frequency	Purpose	Medication	Dose/Frequency	Purpose
1)			7)		
2)			8)		
3)			9)		
4)			10)		
5)			11)		
6)			12)		

Allergies: *Please list all medication, nutritional and environmental allergies*	
1)	4)
2)	5)
3)	6)

Personal Past Medical History: *Please check all that apply to your past medical history.*

	Arthritis		Drug addiction		Liver/gallbladder disease
	Allergies/Hay Fever		Eating disorder		Mental illness
	Asthma		Epilepsy		Mental retardation
	Alcoholism		Emphysema		Migraine headaches
	Alzheimer’s disease		Eyes, ears, nose, throat		Neurological problems
	Autoimmune disease		Environmental sensitivities		Sinus problems
	Blood pressure, high		Fibromyalgia		Stroke
	Bronchitis		Food intolerance		Thyroid trouble
	Cancer		Gastroesophageal reflux		Obesity
	Chronic fatigue syndrome		Genetic disorder		Osteoporosis
	Carpal tunnel syndrome		Glaucoma		Pneumonia
	Cholesterol, elevated		Gout		Sexually transmitted disease
	Circulatory problems		Heart disease		Seasonal affective disorder
	Colitis		Infection, chronic		Skin problems
	Dental problems		Inflammatory bowel disease		Tuberculosis
	Depression		Irritable bowel syndrome		Ulcer
	Diabetes		Kidney or bladder disease		Urinary tract infection
	Diverticular disease		Learning disabilities		Varicose veins
Women Only					
	Anxiety		Infertility		Food cravings
	Irritability		Fibroids		Sweet cravings
	Anger		Bloating		Chocolate cravings
	Agitation		Breast tenderness		Irregular periods
	Cramps		Breast enlargement		Osteoporosis
	Weight gain		Fibrocystic breasts		Autoimmune disorder
	Gall bladder		Mood swings		Muscle pains
	Polycystic ovaries		Blood sugar problems		Joints pains
	Prolonged bleeding		Insomnia		Back pain
	Clots		Cervical dysplasia		Acne
	Water retention		Depression		Foggy thinking
	Cold hands/feet		Headaches/migraines		Decreased sex drive
	Endometriosis				

Family History

Mark the appropriate boxes to identify ALL illnesses or conditions which you know have occurred in you or your blood relatives. Indicate "None" if you are unsure.		Mother ☐ don't know ☐ Alive ☐ Deceased	Father ☐ don't know ☐ Alive ☐ Deceased	Brothers	Sisters	Sons	Daughters	Grandparents	None
Arthritis		☐	☐	☐	☐	☐	☐	☐	☐
Asthma		☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism		☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's disease		☐	☐	☐	☐	☐	☐	☐	☐
Cancer, other		☐	☐	☐	☐	☐	☐	☐	☐
Cancer, breast		☐	☐	☐	☐	☐	☐	☐	☐
Cancer, colon		☐	☐	☐	☐	☐	☐	☐	☐
Cancer, lung		☐	☐	☐	☐	☐	☐	☐	☐
Cancer, ovarian		☐	☐	☐	☐	☐	☐	☐	☐
Cancer, prostate		☐	☐	☐	☐	☐	☐	☐	☐
Depression		☐	☐	☐	☐	☐	☐	☐	☐
Diabetes		☐	☐	☐	☐	☐	☐	☐	☐
Drug addiction		☐	☐	☐	☐	☐	☐	☐	☐
Eating disorder		☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorder		☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma		☐	☐	☐	☐	☐	☐	☐	☐
Heart disease		☐	☐	☐	☐	☐	☐	☐	☐
Infertility		☐	☐	☐	☐	☐	☐	☐	☐
Learning disabilities		☐	☐	☐	☐	☐	☐	☐	☐
Mental illness		☐	☐	☐	☐	☐	☐	☐	☐
Mental retardation		☐	☐	☐	☐	☐	☐	☐	☐
Migraine headaches		☐	☐	☐	☐	☐	☐	☐	☐
Neurological disorders		☐	☐	☐	☐	☐	☐	☐	☐
Obesity		☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis		☐	☐	☐	☐	☐	☐	☐	☐
Stroke		☐	☐	☐	☐	☐	☐	☐	☐
Suicide (attempted suicide)		☐	☐	☐	☐	☐	☐	☐	☐
Other:		☐	☐	☐	☐	☐	☐	☐	☐
Other:		☐	☐	☐	☐	☐	☐	☐	☐

(Physician Use Only)

Social History

***Diet**: Do you follow any particular diet regimens or restrictions?* ______________________________________

Any specific food restrictions? □ dairy □ wheat □ eggs □ soy □ corn □ all gluten □ other

Please number of servings per day you consume of:

Fruits __________ Dark green or deep yellow/orange vegetables __________

Grains (unprocessed) __________ Beans, peas, legumes __________

Dairy, eggs __________ Meat, poultry, fish __________

Eating habits:

□ Skip meals – which ones? ____________________

□ one meal/day □ two meals/day □ three meals/day □ Graze (small frequent meals)

□ Generally eat on run □ Eat constantly whether hungry or not

***Exercise:** Do you exercise regularly? If YES – what do you do? If NO – what keeps you from exercising?*

____

____

***Habits & Lifestyle:** Please circle or list which of the following you use:* Tobacco/Cigarettes (#/day _______)

Alcohol (glasses/day_______) Coffee (cups/day______) Black Tea Cola/Soda (cans/day_____)

Water (glasses/day_________) Aspirin/Tylenol/NSAIDs Antacids Recreational drugs

***Sleep:** (rate quality 0-10, 10 is best)* _____ Hours/night _____

***Stress**: (rate level of stress you are experiencing on a scale of 0 to 10 with 10 being the highest:* __________

Please list your current stressors: ____

____

Goals for Your Care

People see chiropractors for a variety of reasons. Some go for relief pain, some to correct the cause of pain and others for correction of whatever is not working properly in their body. Dr. Sefcik will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ **Relief Care –** symptomatic relief of pain or discomfort

□ **Corrective Care –** correcting and relieving the cause of the problem as well as the symptoms.

□ **Comprehensive Care –** bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

□ ***I want the doctor to select the type of care appropriate.***

(Physician Use Only)

INFORMED CONSENT

Informed Consent to Chiropractic Examination and Treatment

I hereby request and consent to the performance of examination, chiropractic adjustments, manual therapy and any other procedures, including, but not limited to, diagnostic tests, blood testing, salivary testing, diagnostic x-ray(s), physical therapy techniques, and/or neurological therapy techniques on me, my child, or the person named below for which I am legally responsible, which are recommended by Dr. Charles M Sefcik, DC, DACNB, CCN and/or other licensed doctors of chiropractic who now, or in the future, render treatment to me while employed by, working for, associated with, or serving as an on-call doctor for Life Enhancement Clinic, P.C.

I understand that as with any healthcare procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains, and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This very rare event occurs during manipulation with the head in a rotated and extended position – a method of adjusting that is not used in this clinic. I do not expect the doctors to be able to anticipate all risks and complications and I wish to rely on them to exercise judgment during the course of the procedure(s), which they feel at that time, based upon the facts then known, are in my best interest.

1) I hereby authorize Life Enhancement Clinic, P.C. to examine and treat my conditions as they deem appropriate with chiropractic healthcare, and I give authority for performance of these procedures.
2) Life Enhancement Clinic, P.C. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I affirm that I am not currently pregnant or trying to become pregnant. Should this condition change, I will notify Dr. Charles M Sefcik and/or their staff as soon as possible.

Initials __________ Date of last menstrual period ________/_________/________

□ I have read or □ I have had read to me the above explanation of the chiropractic adjustment and related treatments. By signing below, I state that I have weighed the risks involved in undergoing chiropractic care and have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent for chiropractic treatment. I understand the results are not guaranteed.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand the information above and guarantee all forms were completed correctly and to the best of my knowledge. I further understand it is my responsibility to inform this office of any changes in my medical state.

____ ________/_________/________

Patient Signature (or representative if minor or physically incapacitated) Date

Health Insurance Portability and Accountability Act (HIPAA)

Patient consent for use and/or disclosure of protected health information to carry out treatment, payment and health care operations.

I, (Print Name) ____________________________, hereby state that by signing this Consent, I acknowledge and agree as follows:

1) The Privacy Notice includes a complete description of the uses and/or disclosures of my protected healthcare information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its healthcare operations. The Practice explained to me that the Privacy Notice would be available to me at any time in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice before signing this Consent, and has encouraged me to read the Privacy Notice carefully before my signing this Consent.

2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3) I understand that, and consent to, the following that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning and leaving a message on my voice mail or with the individual answering the phone. I also understand my name may be viewed on a sign-in sheet, referral board, and/or clinic newsletter and may be called when the doctor is ready to see you.

4) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific healthcare operations. This includes contacting my general physician, any specialists, and/or any other practitioners I have seen.

5) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, the restriction is binding on the Practice.

6) I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8) I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read, and understand, the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

____ ________/_________/________

Signature of Patient Date