# Matthew J. Lieber, D.C., LLC

**Confidential Patient Data**

*(Please complete this form in full. If you need any assistance, we would be happy to help)*

**General Information** **Today's Date:** _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ please call me at: ☐ home

Work Phone: _____ please call me at: ☐ work

Cell Phone: _____ please call me at: ☐ cell

- **Email Address**: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other _____

Birth Date: _____

Number of Children: _____

Emergency Contact Person: _____ Phone: _____

Current Occupation: _____

Employer Name: _____

Employer Address: _____

**How were you referred to this office?**

☐ Friend/Family Member – Name: _____

☐ Yellow Pages ad ☐ Mail ☐ Website ☐ Passing by ☐ Other_____

**Payment Information** (*please check)*

Responsible Party: ☐ Self ☐ Spouse ☐ Other: _____

Payment for Services: ☐ Insurance ☐ Self-Pay

If Insurance: ☐ HMO ☐ PPO ☐ POS ☐ EPO ☐ HSA/HSP

☐ Auto Insurance ☐ Worker's Compensation

**Primary Insurance Information:**

Social Security #: _____ - _____ - _____ (we require your SS # to file any insurance)

Insurance ID #: _____ (if your ID # is not your SS #)

Group ID #: _____

Special ID #: _____

Primary or Auto Insurance Name: _____ Phone #: _____

Primary or Auto Insurance Address: _____

Secondary Insurance Name: _____ Phone #: _____

Secondary Insurance Address: _____

**Additional "Auto/Worker's Compensation" Insurance Information:**

Claim #: _____

Injury/Loss Date: _____

Adjuster Name (for Auto/Workers Comp): _____ Phone #: _____

Lawyers Name (for Auto Accident): _____ Phone #: _____

Lawyers Address: _____

We are here to meet and exceed your expectations in our office. To accomplish this, we would like to know more about you and what you hope out of your care.

## Goals for care:

| | | | |
|---|---|---|---|
| I want to have less pain? | ☐Yes | ☐No | ☐Unsure |
| I want to feel better? | ☐Yes | ☐No | ☐Unsure |
| I want to be able to move better? | ☐Yes | ☐No | ☐Unsure |
| I want to be more active? | ☐Yes | ☐No | ☐Unsure |
| I want to play more sports? | ☐Yes | ☐No | ☐Unsure |
| I want to have fewer injuries? | ☐Yes | ☐No | ☐Unsure |
| I want to lose weight? | ☐Yes | ☐No | ☐Unsure |

Further Comments:

_____
_____
_____
_____

Please tell us what brought you into the office.

## Present Complaints:

** Please rate your current complaints on a scale of 1 to 10, as described on page 8.*

**1. _____ *Intensity Rating: _____ *Frequency Rating: _____**

2. _____ *Intensity Rating: _____ *Frequency Rating: _____

3. _____ *Intensity Rating: _____ *Frequency Rating: _____

4. _____ *Intensity Rating: _____ *Frequency Rating: _____

Out of all your health problems, which **one would you most** want to have fixed? _____
When did you first notice **this problem**? Approximate or Exact Date: _____
In what manner did **this problem** begin? ☐Suddenly ☐Gradually
From what did **this problem** develop? ☐Job Related Injury ☐Auto Collision ☐Home Injury
☐Illness ☐Unknown ☐Other _____
If known, describe how **this problem** occurred? _____
_____
_____
Have you ever had **this problem** before? ☐Yes ☐No When? _____
Been seen by another Doctor or Therapist for this? ☐Yes ☐No When? _____
If Yes, Name/Location: _____ Phone #: _____
_____

**Surgical History:** **– >** **Previous Surgeries?** ☐Yes ☐No

***If Yes**, please start with most recent first:*

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

**Trauma History:** **– >** **Please list Injuries with the most recent first.**

☐Fall ☐Auto ☐Sport ☐Other 1. _____ Date: _____
☐Fall ☐Auto ☐Sport ☐Other 2. _____ Date: _____
☐Fall ☐Auto ☐Sport ☐Other 3. _____ Date: _____
☐Fall ☐Auto ☐Sport ☐Other 4. _____ Date: _____

**Please show the areas of discomfort in the diagrams below:**

Area of Complaint - Front View

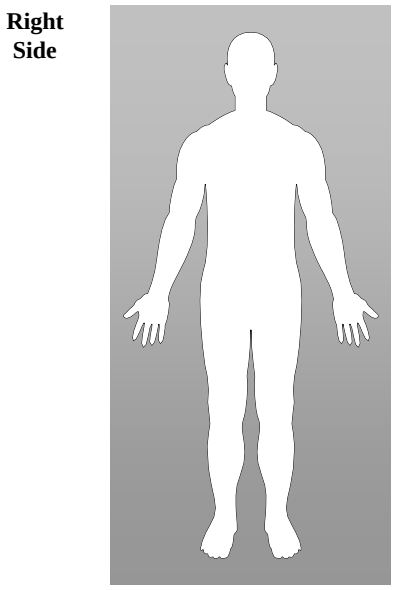


*Figure 1- Shade **FRONT** Areas of in region of complaint and note the type of problem with identifying labels*

**Identifying Labels**
**P = Pain**
**B = Burning**
**N = Numbness**
**S = Sharp**
**A = Ache**
**T = Tension**
**H = Hot**
**C = Cold**

Area of Complaint - Back View

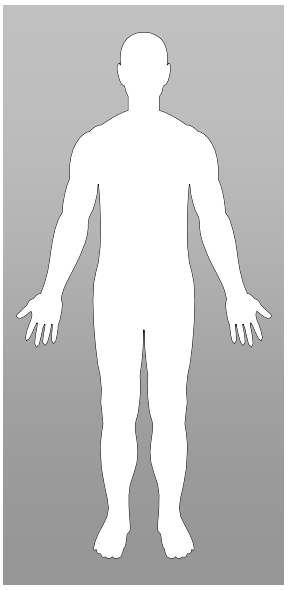


*Figure 2- Shade **BACK** Areas of in region of complaint and note the type of problem with identifying labels*

**Please check all activities that AGGRAVATE/WORSEN your primary complaint:**

☐Bending ☐Reaching ☐Straining at stool ☐Coughing/Sneezing ☐Sitting ☐Standing
☐Lifting ☐Turn head ☐Lying/Sleeping ☐Walking ☐Other _____

**Please check all activities that RELIEVE/IMPROVE your primary complaint:**

☐Bending ☐Reaching ☐Straining at stool ☐Coughing/Sneezing ☐Sitting ☐Standing
☐Lifting ☐Turn head ☐Lying/Sleeping ☐Walking ☐Other _____



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To better understand your current situation, we would like to know more about your past healthcare choices and practices.

## Chiropractic Information:

Have you had previous Chiropractic Care? ☐Yes ☐No If yes? Date of Last Visit: _____

**If Yes:** Chiropractor Name & Location: _____

**If Yes:** Response to care? ☐No Results ☐Positive Results ☐Negative Results

Have you had Spinal X-rays or MRI's taken? ☐Yes ☐No If yes? Date Films Taken: _____

## Other Healthcare Information:

Have you had previous MA Care? ☐Yes ☐No If yes? Date of Last Visit: _____

**If Yes:** Chiropractor Name & Location: _____

**If Yes:** Response to care? ☐No Results ☐Positive Results ☐Negative Results

Have you had Spinal X-rays or MRI's taken? ☐Yes ☐No If yes? Date Films Taken: _____

## General Health History: *(please check)*

Do you feel as if you're in control of your life and health? ☐Yes ☐No

Please **rate** your overall health: ☐Excellent ☐Good ☐Fair ☐Poor

Please **describe** your overall health situation: ☐Improving ☐No Change ☐Worsening

Current Health Practices: ☐Walking ☐Jogging ☐Biking ☐Hiking

***(check all that apply)*** ☐Supplements ☐Homeopathy ☐Herbs

☐Circuit Training ☐Cross fit ☐Weight Lifting ☐Aerobics

☐Swimming ☐Yoga/Pilates ☐Stretching ☐Tai Chi

☐Massage ☐Reflexology ☐Meditation ☐Other

☐Special Diet: _____

☐Supplements: _____

☐Current Sports: _____

☐Water Consumption: _____

**Additional History:** *(please check)*

| | | | | | |
|---|---|---|---|---|---|
| Tobacco usage | ☐None | ☐Past | ☐Light | ☐Moderate | ☐Heavy |
| Alcohol usage | ☐None | ☐Past | ☐Light | ☐Moderate | ☐Heavy |
| Drug usage | ☐None | ☐Past | ☐Light | ☐Moderate | ☐Heavy |
| Exercise | ☐Never | ☐Seldom | ☐Occasional | ☐Never | |
| Sleep | ☐Soundly | ☐Lightly | ☐Restlessly | ☐Rarely | # Hrs: _____ |

Dr. Notes:

_____

_____

_____



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**Family History:** **M = Mother, F = Father** *(Please check appropriate boxes for your parents)*

| M | F | | M | F | | M | F | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Deceased | ☐ | ☐ | Diabetes | ☐ | ☐ | Muscular Dystrophy |
| ☐ | ☐ | Anemia | ☐ | ☐ | Epilepsy/Convulsions | ☐ | ☐ | Polio |
| ☐ | ☐ | Auto-Immune diseases | ☐ | ☐ | Hepatitis | ☐ | ☐ | Spinal Problems |
| ☐ | ☐ | Bad Circulation | ☐ | ☐ | Heart Trouble | ☐ | ☐ | Multiple Sclerosis |
| ☐ | ☐ | Bladder Trouble | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Stroke or CVA's |
| ☐ | ☐ | Cancer | ☐ | ☐ | Kidney Disorder | ☐ | ☐ | Tuberculosis |

**GENERAL Review of Systems:** (***Please check the appropriate "Yes," "No" or "Past" for each of the following. Fill in the blanks where requested. If there are multiple choices per line, circle whichever applies to you***)

**Constitutional, Sleep & Energy**

| | | | |
|---|---|---|---|
| Fatigue | ☐Yes | ☐No | ☐Past |
| Recent change in weight | ☐Yes | ☐No | ☐Past |
| Fever | ☐Yes | ☐No | ☐Past |
| Needs coffee to get started | ☐Yes | ☐No | ☐Past |
| Can't fall asleep | ☐Yes | ☐No | ☐Past |
| Wakes middle of the night | ☐Yes | ☐No | ☐Past |

**Eyes**

| | | | |
|---|---|---|---|
| Double vision | ☐Yes | ☐No | ☐Past |
| Eye Pain | ☐Yes | ☐No | ☐Past |
| Blurred vision | ☐Yes | ☐No | ☐Past |
| Dry eyes | ☐Yes | ☐No | ☐Past |
| Itchy/watery eyes | ☐Yes | ☐No | ☐Past |
| Red/Inflamed eyes | ☐Yes | ☐No | ☐Past |
| Eyes sensitive to bright light | ☐Yes | ☐No | ☐Past |

**Ears**

| | | | |
|---|---|---|---|
| Earaches/Ear pain | ☐Yes | ☐No | ☐Past |
| Discharge from ears | ☐Yes | ☐No | ☐Past |
| Itchy ears | ☐Yes | ☐No | ☐Past |
| Ringing in ears | ☐Yes | ☐No | ☐Past |
| Hearing loss | ☐Yes | ☐No | ☐Past |
| Frequent ear infections | ☐Yes | ☐No | ☐Past |

**Nose & Sinuses**

| | | | |
|---|---|---|---|
| Itchy nose | ☐Yes | ☐No | ☐Past |
| Frequent stuffy nose | ☐Yes | ☐No | ☐Past |
| Must breathe thru mouth | ☐Yes | ☐No | ☐Past |
| Post nasal drip | ☐Yes | ☐No | ☐Past |
| Sinus problems | ☐Yes | ☐No | ☐Past |

**Mouth, Throat & Neck**

| | | | |
|---|---|---|---|
| Mouth/lip sores | ☐Yes | ☐No | ☐Past |
| Swollen tongue | ☐Yes | ☐No | ☐Past |
| Dental/gum problems | ☐Yes | ☐No | ☐Past |
| Painful chewing | ☐Yes | ☐No | ☐Past |
| Frequent sore throat | ☐Yes | ☐No | ☐Past |
| Loss of taste | ☐Yes | ☐No | ☐Past |
| Voice change | ☐Yes | ☐No | ☐Past |
| Swollen glands | ☐Yes | ☐No | ☐Past |
| Jaw pain/stiffness | ☐Yes | ☐No | ☐Past |

**Skin**

| | | | |
|---|---|---|---|
| Rashes | ☐Yes | ☐No | ☐Past |
| Itching | ☐Yes | ☐No | ☐Past |
| Change in skin color | ☐Yes | ☐No | ☐Past |
| Yellowing of skin (Jaundice) | ☐Yes | ☐No | ☐Past |
| Change in hair/nails | ☐Yes | ☐No | ☐Past |
| Poor wound healing | ☐Yes | ☐No | ☐Past |
| Eczema | ☐Yes | ☐No | ☐Past |
| Psoriasis | ☐Yes | ☐No | ☐Past |
| Shingles | ☐Yes | ☐No | ☐Past |

**Lungs & Breathing**

| | | | |
|---|---|---|---|
| Asthma | ☐Yes | ☐No | ☐Past |
| Bronchitis/Pneumonia | ☐Yes | ☐No | ☐Past |
| Smoker | ☐Yes | ☐No | ☐Past |
| Chronic cough | ☐Yes | ☐No | ☐Past |
| Coughing up phlegm | ☐Yes | ☐No | ☐Past |
| Coughing up blood | ☐Yes | ☐No | ☐Past |
| Wheezing | ☐Yes | ☐No | ☐Past |
| Pain/difficulty breathing | ☐Yes | ☐No | ☐Past |
| Shortness of breath | ☐Yes | ☐No | ☐Past |

**Digestive system**

| | | | |
|---|---|---|---|
| Change in appetite | ☐Yes | ☐No | ☐Past |
| Difficulty swallowing | ☐Yes | ☐No | ☐Past |
| Belching/burping | ☐Yes | ☐No | ☐Past |
| Heartburn / Reflux / GERD | ☐Yes | ☐No | ☐Past |
| Nausea/Vomiting | ☐Yes | ☐No | ☐Past |
| Ulcers | ☐Yes | ☐No | ☐Past |
| Liver/Gallbladder disease | ☐Yes | ☐No | ☐Past |
| Intolerance to greasy foods | ☐Yes | ☐No | ☐Past |
| Sensitivity to foods | ☐Yes | ☐No | ☐Past |
| Gas / Bloating / Cramps | ☐Yes | ☐No | ☐Past |
| Constipation (<1 BM/day) | ☐Yes | ☐No | ☐Past |
| Loose stools/diarrhea | ☐Yes | ☐No | ☐Past |
| Hemorrhoids | ☐Yes | ☐No | ☐Past |
| Hernias | ☐Yes | ☐No | ☐Past |

**Musculoskeletal**

| | | | |
|---|---|---|---|
| Muscle weakness | ☐Yes | ☐No | ☐Past |
| Muscle cramps/soreness | ☐Yes | ☐No | ☐Past |
| Muscle jumping | ☐Yes | ☐No | ☐Past |
| Swollen joints | ☐Yes | ☐No | ☐Past |
| Stiff in the morning | ☐Yes | ☐No | ☐Past |
| Herniated/Slipped disk | ☐Yes | ☐No | ☐Past |
| Loss in height | ☐Yes | ☐No | ☐Past |
| Osteoporosis | ☐Yes | ☐No | ☐Past |
| Broken bones | ☐Yes | ☐No | ☐Past |
| Injure easily | ☐Yes | ☐No | ☐Past |
| Unable to Walk/Sit properly | ☐Yes | ☐No | ☐Past |

**Heart**

| | | | |
|---|---|---|---|
| Do aerobic exercise | ☐Yes | ☐No | ☐Past |
| Known heart trouble | ☐Yes | ☐No | ☐Past |
| Rapid beating heart | ☐Yes | ☐No | ☐Past |
| High blood pressure | ☐Yes | ☐No | ☐Past |
| Low blood pressure | ☐Yes | ☐No | ☐Past |
| Chest pain/tightness | ☐Yes | ☐No | ☐Past |
| Heart fluttering | ☐Yes | ☐No | ☐Past |
| Swelling of legs/ankles | ☐Yes | ☐No | ☐Past |
| Heaviness in legs | ☐Yes | ☐No | ☐Past |
| Tired with minor exertion | ☐Yes | ☐No | ☐Past |

**Nervous System**

| | | | |
|---|---|---|---|
| Head injury | ☐Yes | ☐No | ☐Past |
| Diagnosed concussion | ☐Yes | ☐No | ☐Past |
| Frequent headaches | ☐Yes | ☐No | ☐Past |
| Lightheadedness/dizzy | ☐Yes | ☐No | ☐Past |
| Fainting | ☐Yes | ☐No | ☐Past |
| Numbness/tingling | ☐Yes | ☐No | ☐Past |
| Loss of balance | ☐Yes | ☐No | ☐Past |
| Convulsions/seizures | ☐Yes | ☐No | ☐Past |
| Tremors/trembling hands | ☐Yes | ☐No | ☐Past |
| Paralysis | ☐Yes | ☐No | ☐Past |
| Stroke | ☐Yes | ☐No | ☐Past |

**Blood & Circulation**

| | | | |
|---|---|---|---|
| Anemia | ☐Yes | ☐No | ☐Past |
| Easy bleeding/bruising | ☐Yes | ☐No | ☐Past |
| Purple fingers | ☐Yes | ☐No | ☐Past |
| Varicose veins | ☐Yes | ☐No | ☐Past |
| Deep leg pain | ☐Yes | ☐No | ☐Past |
| Cold hands/feet | ☐Yes | ☐No | ☐Past |
| Cuts slow to heal | ☐Yes | ☐No | ☐Past |

**Urinary& General reproductive**

| | | | |
|---|---|---|---|
| Frequent urination | ☐Yes | ☐No | ☐Past |
| Burning/painful urination | ☐Yes | ☐No | ☐Past |
| Inability to hold urine | ☐Yes | ☐No | ☐Past |
| Urination with cough/sneeze | ☐Yes | ☐No | ☐Past |
| Dark urine | ☐Yes | ☐No | ☐Past |
| Strong smelling urine | ☐Yes | ☐No | ☐Past |
| Low back pain | ☐Yes | ☐No | ☐Past |
| Kidney stones | ☐Yes | ☐No | ☐Past |
| Frequent infections | ☐Yes | ☐No | ☐Past |
| Antibiotics for infection(s) | ☐Yes | ☐No | ☐Past |

**Male Reproduction**

| | | | |
|---|---|---|---|
| Testicular lump or pain | ☐Yes | ☐No | ☐Past |
| Difficult with erection | ☐Yes | ☐No | ☐Past |
| Prostate problems | ☐Yes | ☐No | ☐Past |

**Female Reproduction**

| | | | |
|---|---|---|---|
| Yeast infections | ☐Yes | ☐No | ☐Past |
| Pelvic soreness | ☐Yes | ☐No | ☐Past |
| Hysterectomy | ☐Yes | ☐No | ☐Past |
| Osteoporosis | ☐Yes | ☐No | ☐Past |
| Are you possibly pregnant? | ☐Yes | ☐No | |
| If Yes, what tri? | ☐1 | ☐2 | ☐3 |



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**Endocrine**

| | | | |
|---|---|---|---|
| Headaches better by eating | ☐Yes | ☐No | ☐Past |
| Irritable if meal is missed | ☐Yes | ☐No | ☐Past |
| Awaken at night hungry | ☐Yes | ☐No | ☐Past |
| Calmer after eating | ☐Yes | ☐No | ☐Past |
| Shaky between meals | ☐Yes | ☐No | ☐Past |
| Crave sweets | ☐Yes | ☐No | ☐Past |
| Excessive thirst | ☐Yes | ☐No | ☐Past |
| Diabetes | ☐Yes | ☐No | ☐Past |
| Overweight | ☐Yes | ☐No | ☐Past |
| Swollen/bulging eyes | ☐Yes | ☐No | ☐Past |
| Intolerant to Temp Extreme | ☐Yes | ☐No | ☐Past |
| Thyroid problems | ☐Yes | ☐No | ☐Past |

**Psychological & Emotional**

| | | | |
|---|---|---|---|
| Down/Sad/Blue/Depressed | ☐Yes | ☐No | ☐Past |
| Anxious/Tense | ☐Yes | ☐No | ☐Past |
| Suicidal feelings/thoughts | ☐Yes | ☐No | ☐Past |
| Impatient/Moody/Nervous | ☐Yes | ☐No | ☐Past |
| Recent Personality Changes | ☐Yes | ☐No | |

**Medical History:**

Treated by Doctor a/o Therapist for any reason in the last year? ☐Yes ☐No

If yes, please describe reason(s): _____

_____

_____

Date of Last MD/DO/OBGYN Visit: _____

Date of Last Physical: _____

Doctor Name & Location: _____ Phone #: _____

_____

Current Medications? *(including over the counter meds)* ☐Yes ☐No

**If yes:**

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Dr. Notes:

_____

_____

_____

_____

_____

_____

_____

(Please note: All information in this and other patient forms are kept private and confidential according to the 2003 HIPPA guidelines.)

Patient Signature: _____ Date: _____

**(If Minor – under 18) Parent Signature: _____**

**How to rate the INTENSITY of your pain, 1 – 10?**

10 - Your pain is intense, and considered the worst pain you have felt.

9 - Pain is intense, but not the worst pain you have felt in your life.

8 - The pain is significant and intense.

7 - Pain is significant and intense but you can bear it.

6 - The pain is moderate and significant.

5 - The pain is moderate but doesn't get in your way throughout the day.

4 - The pain is a nuisance and annoying.

3 - Pain is mild and distracting.

2 - At its worst, the pain is best described as "a little uncomfortable".

1 - Pain is barely noticeable.

**How to rate the FREQUENCY of your pain, 1 – 10?**

10 - Your pain is constant both during the day and at night.

9 - Your pain is constant, but you can forget about it from moment to moment.

8 - You can forget about the pain for up to an hour at a time.

7 - Your pain can disappear for several hours at a time.

6 - Half of your day can go by without being aware of the pain.

5 - The majority of your day is spent without noticing your pain.

4 - Entire day can go by without noticing the pain.

3 - Several days can go by without being aware of it.

2 - Symptom does not recur more frequently than once a week.

1 - Symptom does not recur more frequently than once a month.