Matthew J. Lieber, DC, LLC

Updated 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: _____**

Medical History:

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

If yes, briefly describe reason: _____

_____

Date of Last Visit: _____

Date of Last Physical: _____

Doctor Name & City: _____ Phone #: _____

Current Medications? *(including over the counter meds)* ❑**None**

Name: _____ ❑ OTC ❑Prescribed Reason: _____

Name: _____ ❑ OTC ❑Prescribed Reason: _____

Name: _____ ❑ OTC ❑Prescribed Reason: _____

Name: _____ ❑ OTC ❑Prescribed Reason: _____

Name: _____ ❑ OTC ❑Prescribed Reason: _____

Are you possibly pregnant? ❑Yes ❑No If Yes, what trimester? ❑1 ❑2 ❑3

Surgical History: – > Surgeries since last visit? ❑None

Please start with most recent first:

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

Trauma History: – > Injuries since last visit? ❑None

Please start with 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: _____

❑Fall ❑Auto ❑Sport ❑Other 5. _____ Date: _____

Present Complaints:

** Please rate your current complaints from 1 to 10, as described on page 7. List the most severe first.*

1. _____	***Intensity Rating: ____**	***Frequency Rating: ____**
2. _____	*Intensity Rating: _____	*Frequency Rating: _____
3. _____	*Intensity Rating: _____	*Frequency Rating: _____
4. _____	*Intensity Rating: _____	*Frequency Rating: _____
5. _____	*Intensity Rating: _____	*Frequency Rating: _____

Dr. Notes: _____

_____

_____

_____

_____

Out of all your health problems, which **one would you most** want to have fixed? _____

When did you first notice **this main 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, briefly describe how **main problem** occurred? _____

_____

_____

_____

Have you ever had **this main problem** before?: ❑Yes ❑No When? _____

How have your symptoms been changing? ❑Improving ❑No Change ❑Worsening

Have any Radiating Pain or Numbness: ❑Yes ❑No Where? _____

Have any change in Urination or Defecation? ❑Yes ❑No How So? _____

Seen by another Dr. or Therapist for **main problem**? ❑Yes ❑No When? _____

If Yes, Name/Location: _____ Phone #: _____

Dr. Notes: _____

_____

_____

_____

_____

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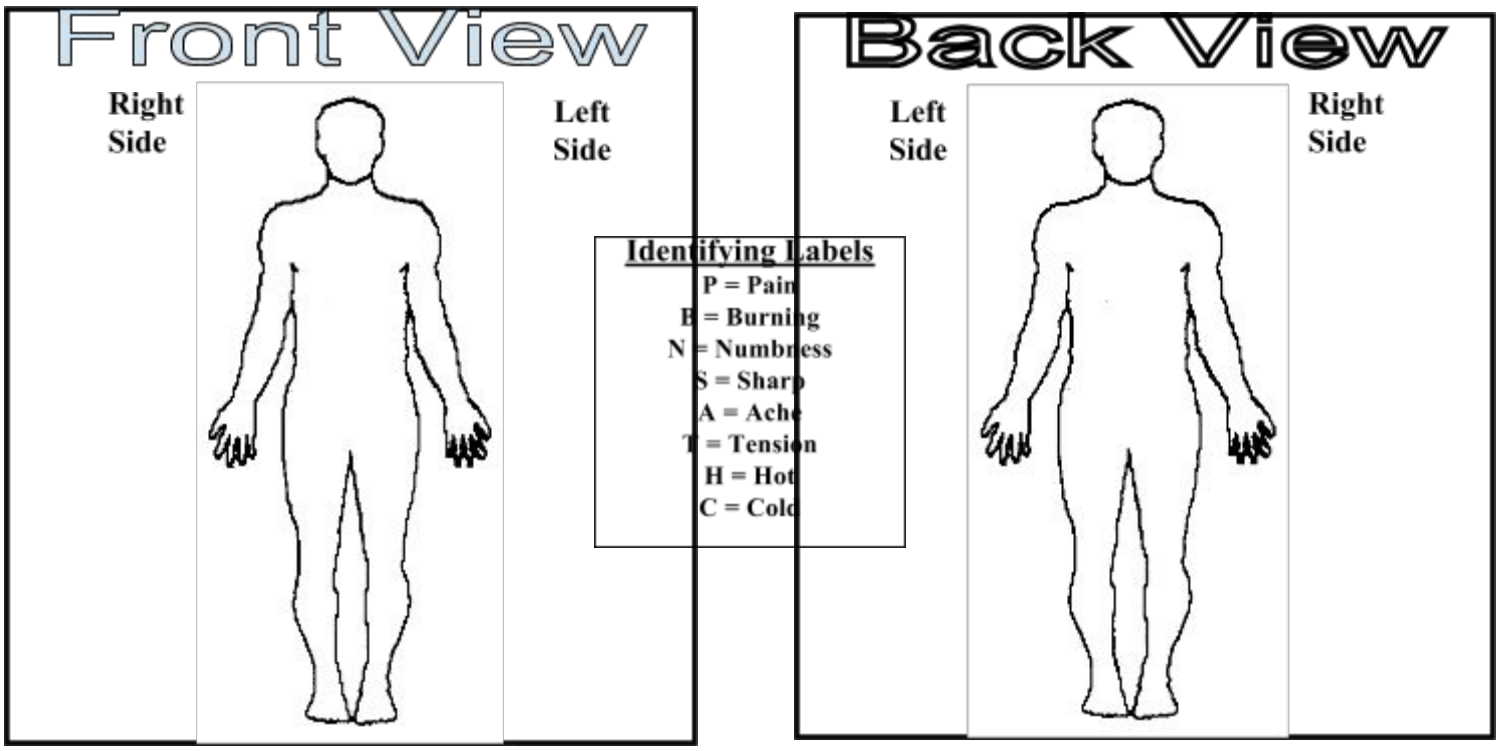
Please show the areas of discomfort in the diagrams below:



Please check all activities that AGGRAVATE/WORSEN your main complaint:

❑Bending ❑Reaching ❑Straining at stool ❑Coughing/Sneezing ❑Sitting
❑Standing ❑Lifting ❑Turning head ❑Lying down/Sleeping ❑Walking
❑Other _____

Please check all activities that RELIEVE/IMPROVE your main complaint:

❑Bending ❑Reaching ❑Straining at stool ❑Coughing/Sneezing ❑Sitting
❑Standing ❑Lifting ❑Turning head ❑Lying down/Sleeping ❑Walking
❑Other _____

Dr. Notes: _____

_____

_____

_____

_____

_____

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

Patient's Signature: _____ Date: _____

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How to rate the INTENSITY of your pain, 0 – 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.

0 - There is NO Pain.

How to rate the FREQUENCY of your pain, 0 – 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.

0 - Symptom has not recurred in the past 6 months..

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