

## Welcome to Lieberman Family Chiropractic

We would like to extend a warm and personal welcome to you. Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an **active, healthy, life**. We will be working together to **help you and your family reach your health and wellness goals**.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your **Doctor's Report**. *Please read and complete the following forms and return them to the front desk on the day of your appointment. Thank you for giving us the opportunity to serve you.*

**At Lieberman Family Chiropractic our purpose is to serve both God and humanity by helping families achieve their optimum, God-given potential for health & well-being of the body, mind & spirit through education, empowerment & principled chiropractic care.**

**Thus, we are committed to providing the highest quality chiropractic care to improve the lives of our patients and change our society's current healthcare paradigm.**

Your attitude about your health is as important to us as is the specific reason you've consulted our office. Below are four prevalent health attitudes.

**Please check the health attitude that most closely reflects your current personal values:**

- TREATMENT ONLY:** I only consult my doctor when I have an ache or pain and discontinue care as soon as it has cleared up.
- PREVENTION:** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from reoccurring.
- MAINTAINING HEALTH:** I'm conscience about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- FAMILY HEALTH:** I take an active part in assisting, informing and maintaining health with my family. I'm concerned with the long-term affects of good health.

**Many of our patients are interested in changing the way they currently view their health. Please circle any of the health attitudes above to which you may aspire.**

**Thank You!**

**You had a choice, and you chose us.**

**We look forward to a healthy relationship with you.**

# LIEBERMAN FAMILY CHIROPRACTIC

## PERSONAL HEALTH HISTORY WELCOME TO OUR FAMILY!

Date \_\_\_\_\_  
Name \_\_\_\_\_ Patient # \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Date Of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Marital Status S M D W E-mail address \_\_\_\_\_  
Spouse's Name & Age \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
Children's Names & Ages \_\_\_\_\_  
\_\_\_\_\_  
Name of Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Hobbies \_\_\_\_\_  
Who Referred You \_\_\_\_\_

Name Of Previous Chiropractors \_\_\_\_\_ When was your last visit? \_\_\_\_\_  
For how long were you receiving Chiropractic adjustments? \_\_\_\_\_

**Reason for coming in** \_\_\_\_\_

What accidents have you had (ex. Bicycle, car, motorcycle, sports, slips/falls) at work or at home (include dates) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you ever knocked unconscious? \_\_\_\_\_  
What fractures or broken bones have you had? (include dates) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **SURGERY:**

What major surgery have you had? (include dates) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What minor surgery have you had? (tonsillectomy, appendectomy, wart/cyst removal, dental extraction) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **MEDICATION:**

Present Prescription Drugs

Past Prescription Drugs

Over-The-Counter Drugs  
(aspirin, cold tablets, cough syrup)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **THERAPY:**

Are you presently under any therapeutic care? (what type) \_\_\_\_\_

What therapeutic care have you been under in the past (radio, chemo, physio, electro, etc., include dates) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**YOUR BIRTH RECORD:**

Type of birth (Vaginal, Cesarean, etc.) \_\_\_\_\_

Any complications during your mothers pregnancy or during your birth? \_\_\_\_\_

Any complications after your birth? \_\_\_\_\_

**CURRENT HEALTH:**

How would you describe your current health? \_\_\_\_\_

How would you describe your family's health? \_\_\_\_\_

Describe your: Vision \_\_\_\_\_ Hearing \_\_\_\_\_ Coordination \_\_\_\_\_

Do you use any of the following: Tobacco Alcohol coffee/tea regular cola diet cola milk

Level of stress in your life: mild moderate extreme 1 2 3 4 5 6 7 8 9 10

Do you purchase any of the following: **Bottled Drinking Water:** ( ) No ( ) Yes

Vitamins: ( ) No ( ) Yes **Health Food Products** (organic products, etc.) ( ) No ( ) Yes

**FINANCIAL INFORMATION:**

Who is responsible for this account? \_\_\_\_\_

What method of payment will you be using? Insurance Cash Check MC/Visa/Discover/AmEx Other

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

Do you have secondary insurance? ( ) Yes ( ) No

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Pease check any of the following that give you difficulty or you have had recently

- |                                                            |                                                           |                                                     |                                                     |
|------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> <b>Headaches 784.0</b>            | <input type="checkbox"/> Fainting 780.2                   | <input type="checkbox"/> Shortness of breath 786.0  | <input type="checkbox"/> Asthma 493.9               |
| <input type="checkbox"/> Shooting head pains 784.0         | <input type="checkbox"/> Loss of balance 781.2            | <input type="checkbox"/> Menstrual Cramp/Pain 625   | <input type="checkbox"/> Constipation 564.0         |
| <input type="checkbox"/> <b>Sinus Trouble 473.9</b>        | <input type="checkbox"/> Ringing in the ears 388.3        | <input type="checkbox"/> Heart attack 410.9         | <input type="checkbox"/> Kidney trouble 593.9       |
| <input type="checkbox"/> <b>Neck Pain 723.1</b>            | <input type="checkbox"/> Blurred vision 368.0             | <input type="checkbox"/> Low blood pressure 458.9   | <input type="checkbox"/> Loss of taste 781.1        |
| <input type="checkbox"/> Allergies 995.3                   | <input type="checkbox"/> Lights bother eyes 368.13        | <input type="checkbox"/> High blood pressure 401.9  | <input type="checkbox"/> Inflammation of throat 462 |
| <input type="checkbox"/> Muscle Spasms in neck 781         | <input type="checkbox"/> Stomach trouble 789              | <input type="checkbox"/> Anemia 285.9               | <input type="checkbox"/> Diabetes 250.0             |
| <input type="checkbox"/> Grinding in neck 719.4            | <input type="checkbox"/> Nerves/Nervousness 799.2         | <input type="checkbox"/> Menstrual Irregularity 626 | <input type="checkbox"/> Thyroid trouble 246.9      |
| <input type="checkbox"/> Shoulder/arm tight 728.85         | <input type="checkbox"/> Inner Tension 799.2              | <input type="checkbox"/> Sleeping Problems 780.5    | <input type="checkbox"/> Painful joints 719.4       |
| <input type="checkbox"/> Shoulder/arm pain 719.4           | <input type="checkbox"/> Irritability 799.2               | <input type="checkbox"/> Pain in legs/feet 719.4    | <input type="checkbox"/> Swollen joints 719.0       |
| <input type="checkbox"/> Pins & Needles in arms 782        | <input type="checkbox"/> Indigestion 536.8                | <input type="checkbox"/> <b>Hip Pain 719.45</b>     | <input type="checkbox"/> Pins & needles in leg 782  |
| <input type="checkbox"/> <b>Numbness in arms/hands 782</b> | <input type="checkbox"/> <b>Low back pain 724.2</b>       | <input type="checkbox"/> Gall bladder trouble 579   | <input type="checkbox"/> Swollen ankles 782.3       |
| <input type="checkbox"/> Mid-back pain 724.1               | <input type="checkbox"/> Cold hands 782                   | <input type="checkbox"/> Loss of Smell 781.1        | <input type="checkbox"/> Cold feet 782              |
| <input type="checkbox"/> <b>Fatigue 780.7</b>              | <input type="checkbox"/> <b>Numbness in legs/feet 782</b> | <input type="checkbox"/> Intestinal Gas 787.3       | <input type="checkbox"/> Facial twitch 781          |
| <input type="checkbox"/> <b>Depression 311.0</b>           | <input type="checkbox"/> Tonsillitis 784                  | <input type="checkbox"/> Hay Fever 477.8            | <input type="checkbox"/> Loss of Memory             |
| <input type="checkbox"/> Dizziness 780.4                   | <input type="checkbox"/> Prostate Trouble 601.4           | <input type="checkbox"/> Hernia 550.1               | <input type="checkbox"/> Facial pain 784.0          |
| <input type="checkbox"/> Spinal curvature 737.43           | <input type="checkbox"/> Bed wetting 788.3                | <input type="checkbox"/> Stroke 436.0               | <input type="checkbox"/> Jaw pain (TMJ) 525.9       |
| <input type="checkbox"/> Earache                           | <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Arthritis 716.96           | <input type="checkbox"/> Ulcers 534.9               |
| <input type="checkbox"/> Seizures                          | <input type="checkbox"/> Other _____                      |                                                     |                                                     |

Dr.'s Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# ORIGIN OF YOUR SUBLUXATION

Which pain or condition you have checked is the worst? \_\_\_\_\_

Many of our patients have had literally dozens of stresses that can cause subluxations. We would like to discover several of yours. Please list stresses regardless of severity. Write N/A if a question does not apply.

1. When was your most recent stress or strain at work? \_\_\_\_\_
  - a. Was treatment received? **YES / NO** If yes, where? What type of treatment? \_\_\_\_\_
  - b. When was the one before that? \_\_\_\_\_
  - c. What types of jobs have you done? \_\_\_\_\_

2. What sports or recreational activities have you been involved in? \_\_\_\_\_
  - a. When was your most recent stress or strain during your activity? \_\_\_\_\_
  - b. Was treatment received? **YES / NO** If yes, where? What type of treatment? \_\_\_\_\_
  - c. When was the one before that? \_\_\_\_\_

3. When was your most recent auto accident? \_\_\_\_\_
  - a. Speed: \_\_\_\_\_
  - b. **FRONT, SIDE** or **REAR-END** collision?
  - c. Was treatment received? **YES / NO** If yes, where? What type of treatment? \_\_\_\_\_
  - d. Please list dates of any other auto accidents \_\_\_\_\_

4. Is there any other injury to your spine or nervous system, minor or major?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# LIEBERMAN FAMILY CHIROPRACTIC

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. **100% body function.**

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I do hereby authorize the doctors of Lieberman Family Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments or any other procedure that is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand that any sum of money paid by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

### Authorization for care of Minor

I hereby agree to allow Lieberman Family Chiropractic, P.C. and its doctors to administer care to my son/daughter, as they may deem necessary. I clearly understand and agree that I am personally responsible for payment for all fees charged by Lieberman Family Chiropractic, P.C..

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_