

Application For Admission

The Liebell Clinic: Chronic Pain Solutions Center

If you are reading this you have been fortunate enough to qualify for a *consultation* with Dr. Donald Liebell. This however does NOT mean that your case has been accepted. Your consultation today will determine if...

A) You are a legitimate candidate for one of the doctor's treatment programs and... **B)** Your condition is serious enough to warrant your case being accepted for treatment. In the event your condition IS serious enough to warrant being considered for acceptance and Dr. Liebell is unavailable to treat you, your case will be referred to another clinic.

Name _____ Today's Date _____ Social Security# _____

Age _____ Birthday _____ Sex: ___M ___ F Address _____

City _____ State _____ Zip _____ Home Phone _____

Work Phone _____ Cell Phone _____ Email (print clearly) _____

Best Place To Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? ___Yes ___ No

Employer _____ Occupation _____ Length of Employ _____

Marital Status: Single Married Widowed Divorce Spouses Name _____

I (signature) _____ consent to allow Dr. Liebell to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for treatment and also to determine if he is willing to accept my case.

How Did You Hear About Dr. Liebell? _____

1 How Serious Do You Think Your Problem Is? _____

What Is Your Main Problem/Symptom Prompting Your Request For A Consultation With The Doctor?

Would You Consider This Problem (check one).... MINIMAL (Annoying but causing NO limitations)
 SLIGHT (Tolerable but causing a little limitation) MODERATE (Sometimes tolerable but definitely causing limitations)
 SEVERE (Causing Significant limitations) EXTREME (Causing near constant (>80% of the time) limitations)

1 In spite of the fact that you are not a spinal specialist, you are in fact the person who knows more about your body than anyone else. In your own words and in your own opinion what do you think the real problem is?

2. What are you hoping happens today as a result of your consultation with the Doctor?

3. Since your condition became this severe what three things has it caused you to miss the most?

3. How long have you been like this? _____

4. How has your life changed since your condition became a problem? _____

5. What activities are you limited in? _____

6. What kinds of treatments have you received (circle)? Bed Rest Over-the-counter pain medicine (like Tylenol, aspirin, Advil, etc)
Medically prescribed pain-killers Muscle relaxers Massage Chiropractic Acupuncture Physical therapy Steroid Injections Surgery
Other treatments _____

7. Did any of these treatments work? If so which one(s)? For how long? _____

8. Is there anything you can do that makes it feel better? _____

9. What activities/movements are guaranteed to make it worse? _____

10. Please describe the quality of the pain. (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc.) _____

11. Is it worse in the morning or is it worse as the day progresses? _____

12. If you cannot find a solution to this problem what do you think will happen to you? _____

13. What are you hoping Dr. Liebell tells you today? _____

14. Describe what you hope or think he might be able to do for you. _____

15. Describe what will be different in your life if you can get better. _____

16. When is the VERY FIRST time you recall having this problem? _____

17. Circle all tests you've had: X-rays MRI CAT scan Bone scan Blood tests Nerve tests Discogram

List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above.

1. _____ How Long Have You Had This? _____

2. _____ How Long Have You Had This? _____

3. _____ How Long Have You Had This? _____

4. _____ How Long Have You Had This? _____

In Reference To Your MAIN PROBLEM How Often Are You Aware of This Problem? (check one)

Occasionally (25% of the time) Intermittently (50% of the time) Frequently (75% of the time) Constant (90-100% of the time)

Due To Your Main Problem....

Have You Lost Any Time From Work? Yes No

How Much Time and What Tasks Have Been Limited? _____

Have You Lost Any Time From Your Chores/Tasks At Home? Yes No

How Much Time and What Tasks Have Been Limited? _____

Have You Lost Any Time From Your Family? Yes No

How Much Time and What Tasks Have Been Limited? _____

Have You Lost Any Time From Your Leisure Activities? (Hobbies, Travel, Sports, etc..) Yes No

How Much Time and What Tasks Have Been Limited? _____

Considering the amount of pain/discomfort you've had THIS week, how long has your problem been this severe? _____

On a Scale of 0 - 10 (10 being unbearable, 0 being No Pain or Discomfort) Please rate the following..

The HIGHEST your pain gets WITHOUT medication _____

The LOWEST your pain gets WITHOUT medication _____

The HIGHEST your pain gets WITH medication _____

The LOWEST your pain gets WITH medication _____

List ANY surgeries that you have had and the corresponding dates. _____

**Have you had ANY of the following in the last 12 months or currently?
(Mark C for Current. X for in last 12 months)**

- GENERAL:** Chills Convulsions Dizziness
 Fainting Fatigue Fever Headache
 Allergy _____
 Loss of Sleep Weight loss Nervousness
 Wheezing Bronchitis
 Numbness in BOTH hands AND feet _____

- CARDIOVASCULAR:** High Blood Pressure
 Low Blood Pressure Pain over heart
 Poor Circulation Rapid Heartbeat
 Previous Heart Problem _____
 Slow Heartbeat Stroke TIA
 Swollen Ankles Varicose Veins
 Aortic Aneurysm Bruise Easily

DISEASES/CONDITIONS

- Appendicitis Anemia Arthritis
 Alcoholism Abdominal Surgery
 Bleeding Disorder Blood Clot(s)
 Breathing Difficulty Cancer
 High Cholesterol Colon Problems
 Diabetes Depression Epilepsy Eczema
 Eating Disorder Glaucoma HIV +
 Heart Disease Hernia Headaches
 Influenza Kidney Disease Liver Disease
 Low back Pain Mental Illness Measles
 Mumps Pleurisy Pneumonia Polio
 Prostate Problems Hyperthyroid
 Hypothyroid Take Synthroid?
 Rectal Surgery **Peripheral Neuropathy**

- EARS/EYES/NOSE/THROAT:** Asthma
 Crossed Eyes Double Vision
 Blurred Vision Difficulty Swallowing
 Deafness Hearing Loss Ear Pain
 Nose Bleeds Sinus Problems Sore Throats

- GASTRO-INTESTINAL:** Constipation Gas
 Colon Trouble Diarrhea Hemorrhoids
 Gallbladder Trouble Liver Trouble
 Stomach Ache Nausea Poor Appetite
 Poor Digestion Vomiting Vomiting Blood
 Rectal Bleeding Bloating

- GENITO-URINARY:** Blood in Urine
 Frequent Urination Inability to control urine
 Kidney Infection Painful Urination
 Prostate Trouble Painful Urination

- FOR MEN ONLY:** Lump in testicles
 Penis discharge

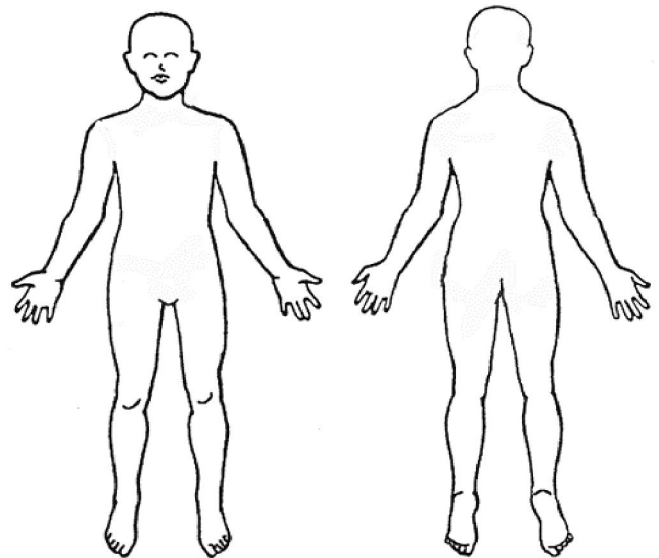
- FOR WOMEN ONLY:** Irregular Cycle
 Painful Periods Hot Flashes **Pregnant**
 Menstrual Cramps Excessive flow
 Abnormal Pap Birth Control Pills

- MUSCLE/JOINT/BONE:** Backache
 Foot Trouble Pain Between Shoulders
 Painful Tailbone Stiff Neck **Osteoporosis**
 Pars defect Spinal Curvature Swollen
 Joints **I've had spinal fusion surgery**
 I have advanced Spondylolisthesis

- NEUROLOGIC:** Seizures Dizziness
 Tremors Weakness Speech Difficulty
 Memory Loss Loss of coordination

- RESPIRATORY:** Chest Pain Chronic Cough
 Difficulty Breathing Coughing/Spitting Blood
 I'm a Smoker I use recreational drugs

**Please Mark an "X" on ALL areas of PAIN
on the diagram below**



Insurance Information - Optional

****If Dr. Liebell accepts you as a patient, it's possible that you may have some insurance coverage for treatment. If you'd like our staff to verify any benefits and extent of coverage, please fill out this section.**

Insurance Policy Holder's # (if other than YOU) _____

Name of Insurance Policy Holder (if not YOU) _____

Relation to Policy Holder: Spouse Child Self _____

Insurance Policy # _____ Is your condition work related? Yes No

Date of Birth of Insurance Policy Holder _____ Policy Holder sex: Male Female

Is this condition from an Auto Accident? Yes No If YES, what state? _____

Name of Policy Holder's employer or school _____ Work Phone # _____

Is your condition related to another accident? Yes No

Primary Insurance Plan Name _____ Secondary Insurance Plan Name _____

Name of Insurance Company _____ Insurance Company Phone# _____

Date your policy took effect _____ What is your deductible? _____

Was your deductible met as of today? Yes No Not sure

If NOT met, it will be paid by Cash Check Credit Card Other _____

Authorization for Care, Insurance Assignment & Fees

Please read and sign (unless you have been in an auto accident - see separate form)

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I understand that this office will assist me in collecting payment from the insurance company and that any amount authorized to be paid directly to this doctor's office will be credited to my account on receipt (assignment of benefits). I clearly understand and agree that I am personally responsible for payment for services rendered. I also understand that if I suspend or terminate care, any fees for services rendered me will be immediately due and payable.

I hereby authorize the doctor to provide for me examination, x-rays (if necessary), and spinal treatment. I also understand that any x-ray fees paid are for the expert analysis and taking of the films, and that the negatives will remain the property of Dr. Liebell. They may however, be seen or borrowed at any time upon request. I understand that I am responsible for all fees for service provided at this office including interest (19.3 % A.P.R.) on unpaid balances or debt, collection fees, court fees, attorney fees (33.3%) and all additional costs to this office as a result of any debt. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature _____ Date _____

For Treatment of a Minor: As parent(s) of the patient named above, a minor, I (we) authorize Dr. Donald Liebell to provide chiropractic examination and treatment:

Guardian or Custodian's Signature Authorizing Care _____ Date _____

Witness _____ Date _____