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

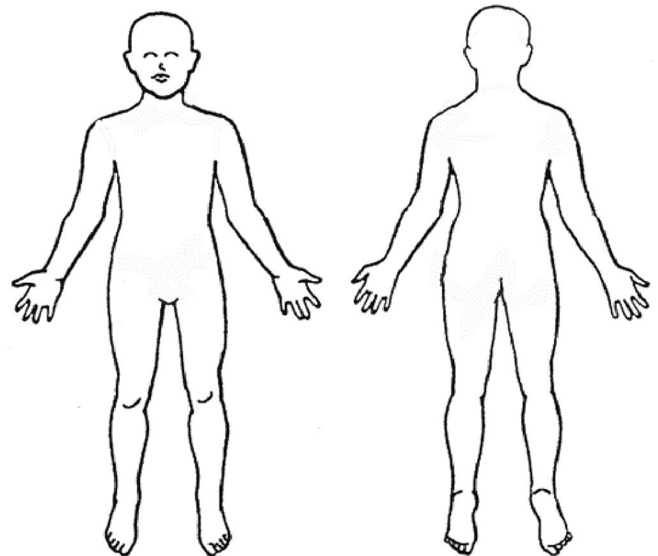
FOR WOMEN ONLY: ☐ Irregular Cycle
☐ Painful Periods ☐ Hot Flashes ☐ **Pregnant**
☐ Menstrual Cramps ☐ Excessive flow
☐ Abnormal Pap ☐ Birth Control Pills

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



Dr. Donald Liebell, D.C., B.C.A.O – 477 Viking Drive Suite 170 Virginia Beach, VA 23452 (757) 631-9799 Fax: (757) 631-9866

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_____________