LIBERMAN CHIROPRACTIC CENTERS – Dr. Michael J. Liberman, D.C.

The Pavilions of Voorhees
2301 Evesham Road, Ste. 302
Voorhees, NJ 08043
Tel. 856-770-1313
Fax 856-770-1297

Date:_____

Patient's Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

E-mail:_____

Social Security #:_____

Date of Birth:_____

Marital Status: M S D W DP

Occupation:_____

Employer:_____

Address:_____

Referred to our office by:_____

PATIENT NAME:_____

General Information:
Date of Injury:_____
Marital Status:_____M_____S_____W_____D
Habits:
Smoke:_____None_____Yes- Pk/Day_____Years_____
_____Moderate_____Social_____Light
Alcohol:_____Never_____Social_____Light
_____Moderate_____Heavy
Employment:
At time of accident:_____
Currently:_____
___Unemployed_____Disabled Last date worked_____
Due to accident? _____Yes _____No
Type of work:_____Office/Clerical _____Light labor
_____Moderate labor _____Heavy labor
Past Medical history:
Surgeries
(dates):_____

Fractures
(dates):_____

Serious illness (dates):
_____

Workers comp injuries (date, treatment, awards, residuals):_____

Sports or other injuries to head, neck or back: _____

Any prior history of current complaints:
1._____
2._____
3._____
Prior treatment by chiropractor for these:
1._____
2._____
3._____

PATIENT NAME:_____

Current Medical History:
Current health problems:_____None_____Please list
_____
_____
_____
Current medication taken:_____None_____Please list
_____
_____
_____

Accident history, General:
Was the accident on-the-job?_____Yes_____No
You were:____Driver ____Front seat passenger
____Rear seat passenger____Motorcycle operator
_____Motorcycle passenger_____Other
Vehicle driven by:_____
Your vehicle (year, make, model):_____
Your estimated speed at moment of accident:_____
____Stopped____Slowing____Accelerating
Time of day:
Daylight____Dawn____Dusk___Dark
Road conditions: ____Dry ____Damp ____ Wet
____Snow ____ Ice ____Other _____
Head restraints:_____None ____Integral type
____Adjustable type: ____Up ____ Down
____ Don't know
If adjustable, was the position altered by the accident?
____ Yes ____ No
Was the seat back adjustment altered by the accident?
____Yes ____No
Was the seat broken? ____Yes ____ No
Lap belt: ____Wearing ____Not wearing
____don't know
Shoulder belt: ____None ____Wearing ____ not wearing _____don't know
Did air bag deploy? ____Yes ____No
If yes, were you struck? ____ Yes ____ No
Body position:____Good ____Forward lean
Other:_____
Head position: ____ forward _____ left (°)
____Right(°)____Up(°)____Down(°)
Hands:____one on wheel____two on wheel____N/A
Brakes applied? _____Yes_____No
Accident description:_____
_____
_____
_____
_____

Accident Diagram:

Aware of impending crash? _____Yes _____ No

During the crash:

Did you strike any parts of the vehicle: _____Yes _____No

If yes,
describe_____

Did the vehicle strike any objects after the crash?_____

If yes,
describe:_____

Wearing hat or glasses? _____ Yes _____ No

If yes, still on after crash? _____Yes _____ No

Did you lose consciousness? _____ Yes _____ No

If yes, for how long?
_____

Estimated property damage to your vehicle:
$_____
_____

Estimated damage to other vehicle(s):_____None
_____Minimal_____Moderate_____Major

Were the police on-scene? _____ Yes _____ No

If yes, was a report made? _____Yes _____ No

After the crash:

Symptoms:_____ Headache _____ Dizziness
_____ Nausea _____ Confusion/disorientation
_____Neck pain_____Paresthesia(s)

If yes,
where?_____

Back pain? _____Yes _____ No

If yes,
where?_____

When did the symptom first appear? _____Immediately
_____hour afterward- (describe symptom)_____
_____

PATIENT NAME:_____

Where did you go after accident? _____Home
___Work___Hospital-which one?_____

Mode of transportation:_____

Family doctor:_____

Emergency department:

Radiographs:_____Yes_____No

Body parts imaged:_____

Results_____

Lab work____Yes _____ No

Cervical collar_____Yes _____ No

Medications_____

Other_____

Follow up instructions_____
_____None

Treatment history:

Dr._____

Specialty:_____date first seen_____

Referred by_____treatment type_____

Treatment frequency and
duration_____
_____

Tests:_____

Currently treating?_____Yes_____No

Any disability:_____Yes_____No

If yes, describe:_____

Special tests:_____

Referred to:_____

Did treatment help? _____ Yes _____ No

Notes:_____
_____

***

Dr._____

Specialty_____date first seen_____

Referred by_____treatment type_____

Treatment frequency and
duration_____
_____

Tests:_____

Currently treating?_____ Yes _____ No

Any disability?_____Yes _____ No

If yes, describe:_____

Special tests:_____

Referred to:_____

Did treatment help?_____ Yes _____No

Notes:_____
_____

Current chief complaints:

-1-

Body part/system:_____
Onset:_____
Provocative (what makes it worse):_____
_____
Palliative (what reduces pain):_____
_____
Quality (describe pain):_____
_____
Radiation (referral into arm, leg):_____
_____
Severity (1-10):_____

-2-

Body part/system:_____
Onset:_____
Provocative:_____
Palliative:_____
Quality:_____
Radiation:_____
Severity (1-10):_____

-3-

Body part/system:_____
Onset:_____
Provocative:_____
Palliative:_____
Quality:_____
Radiation:_____
Severity (1-10):_____

-4-

Body part/system:_____
Onset:_____
Provocative:_____
Palliative:_____
Quality:_____
Radiation:_____
Severity (1-10):_____

-5-

Body part/system:_____
Onset:_____
Provocative:_____
Palliative:_____
Quality:_____
Radiation:_____
Severity (1-10):

Self assessment as of today: %improved (list for separate areas)

FOR DOCTOR TO COMPLETE:

- --Request radiographs from:_____
  _____
- --Request records from:_____
  _____
- –Request copy of police report.

Referral:

- –For:_____
- –To:_____

Tests to order:

- Radiographs:_____
- CT:_____
  Area(s)_____
- MRI:_____
  Area(s)_____
- EMG/NCV:_____
  Root level/nerve(s):_____
- SEP:_____
  Root level/nerve(s):_____
- Other electrodiagnostic test(s):_____
  _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOU PROBLEM RIGHT NOW.**

SECTION 1-PAIN INTENSITY

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (WASHING, DRESSING, ETC.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help everyday in most aspects of self care.
F I do not get dressed, I wash difficultly and stay in bed.

SECTION 3-LIFTING

A I can lift heavy weights, without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can.
D Pain prevents me from lifting heavy weights o, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4-READING

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read at all.

SECTION 5-HEADACHES

A I have no headaches at all.
B I have slight headaches which come in frequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

After Vernon & Mior, 1991
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SECTION 6-CONCENTRATION

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7-WORK

A I can do as much as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8-DRIVING

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want because of moderate pain in my back.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9-SLEEPING

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than one hour).
C My sleep is mildly disturbed (1-2 hours).
D My sleep is moderately disturbed (2-3 hours).
E My sleep is greatly disturbed (3-5 hours).
F My sleep is completely disturbed (5-7 hours).

SECTION 10-RECREATION

A I am able to engage in all of my recreational with no activities, neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D I am able to engage in a few of my usual recreational activities because of pain in my neck.
E I am hardly able to do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

Comments:_____
_____

Patient's signature:_____
Date:_____

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please read: The questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you. **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBED YOUR PROBLEM RIGHT NOW.**

SECTION 1-PAIN INTENSITY

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2-PERSONAL CARE

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing or dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3-LIFTING

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4-WALKING

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than ½ mile.
D Pain prevents me from walking more than ¼ mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5-SITTING

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than ½ hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

From: N. Hudson, K. Tome-Nicholson, A. Breen;

SECTION 6-STANDING

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than ½ hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7-SLEEPING

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one -quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8-SOCIAL LIFE

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9-TRAVELING

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10-CHANGING DEGREE OF PAIN

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Comments:_____
_____
_____
_____
_____
_____
_____

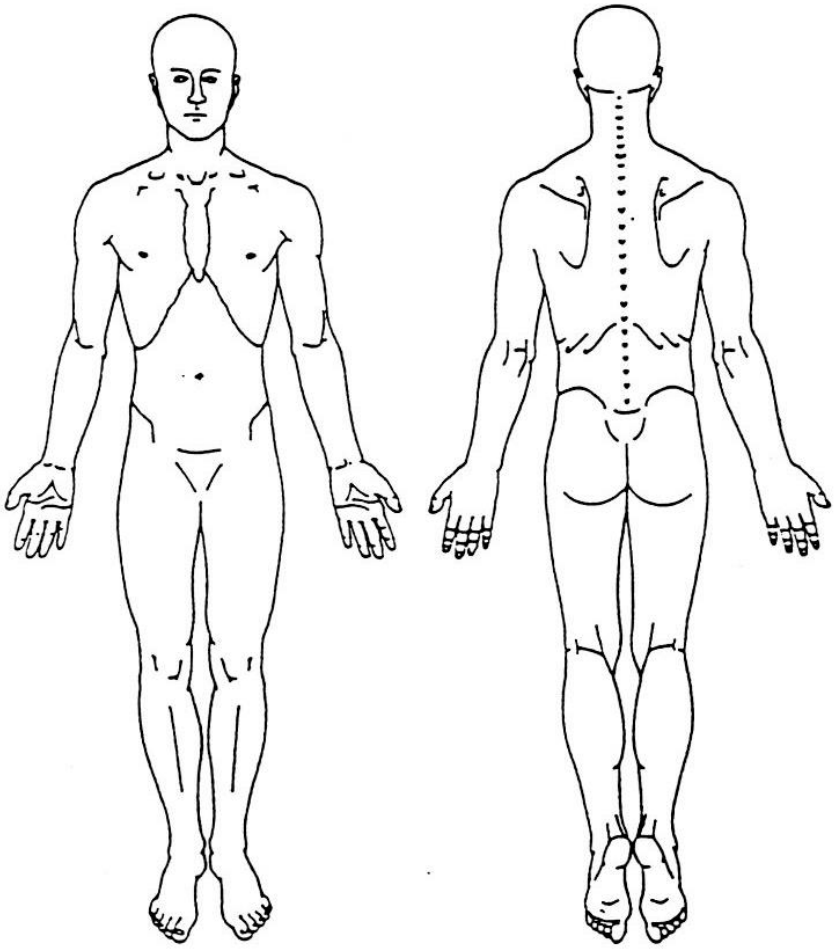
Patient's signature:_____
Date:_____

PAIN DIAGRAM

Instructions:

On the body diagram below, please indicate where your pain is located at the present time by using the letter abbreviations that most accurately reflect the type of pain or discomfort that you are experiencing. Please do not indicate areas of pain that are not related to your present injury or condition.

N = numbness & tingling D = dull pain P = sharp pain B = burning pain S = stiffness



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

No Pain — Worst Pain Possible

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Thank you for choosing our office for your health care. We are committed to providing you with quality care. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The following is a statement of our Financial Policy. We ask that you review it and sign it prior to treatment.

It is your responsibility to know the terms of your insurance policy. Please make sure you give us your current insurance information at each visit. A co-pay or payment in full, if required by your insurance company, is expected at the time of service or your appointment may be rescheduled. This applies to all visits including follow-up visits. You may need to check with your primary care physician for referrals or outside tests.

I understand and agree with all of the following policies and statements:

1. I understand I am required to pay my deductible and co-insurance at the time services are rendered. Acceptable methods of payment are cash, checks, Visa, and Master Card.
2. I understand that I am responsible for acquiring referrals prior to my appointment. If a referral was not issued, I will pay all fees for that date of service.
3. The physician's office does not guarantee that my insurance will pay for services. The office staff will make every attempt to receive verification and benefits of my policy. However, if my insurance claim is denied, I will be responsible for the full amount of my bill.
4. The physician's office will NOT enter into a dispute with my insurance company over my claim. I understand this is my responsibility and obligation.
5. If a payment plan is required, there will be a one and one half percent service charge per month. This shall be added to any balance remaining after 30 days from my initial visit. I also agree to pay all costs of collection of any balance, including attorney fees if applicable.
6. The office staff will submit requested documentation on my behalf to my insurance company. The charge for completing medical forms (disability, leave of absence, etc.) is $10.00 to $15.00. Forms will be completed as time permits usually within one week. Copies of medical records are available at $0.50 per page. All returned checks will be assessed an additional charge of $30.00 per check.
7. **The following checked statement is true**:
   ___Yes, I have been associated with a malpractice suit.
   ___No, I have never been associated with a malpractice suit.
8. I consent to evaluation and treatment by the doctor. If I have questions, I will ask the doctor prior to treatment.
10. In most cases, you will receive a reminder call 1 to 2 days before your visit. If you are unable to keep your appointment, kindly give us at least 24 hours notice. (You can leave a message with the answering service during non-business hours). I understand that if I miss an appointment without giving notice, I will be billed a **$25 fee**. This No-Show fee will NOT be billed to my insurance company.

By signing my name below, Liberman Chiropractic will accept my insurance assignment.

_____ _____

Signature Date

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

(HIPAA AGREEMENT)

Woodbury Family Chiropractic & Liberman Chiropractic

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I had the opportunity to read and understand the Notice.

_____ _____/_____/_____
Patient's Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

I am also giving my consent to discuss my treatment with the following individuals:

_____ _____
Name Relationship

_____ _____
Name Relationship

FINANCIAL POLICY

Thank you for choosing our office for your health care. We are committed to providing you with quality care. The following is a statement of our Financial Policy. We ask that you review it and sign it prior to treatment.

It is your responsibility to know the terms of your insurance policy. Please make sure you give us your current insurance information at each visit. A co-pay or payment in full, if required by your insurance company, is expected at the time of service or your appointment may be rescheduled. This applies to all visits including follow-up visits. You may need to check with your primary care physician for referrals or outside tests.

If there is an outstanding balance, it is to be paid before seeing the provider. We accept cash, checks, Visa and MasterCard.

MISSED APPOINTMENTS

In most cases, you will receive a reminder call 1 to 2 days before your visit. If you are unable to keep your appointment, kindly give us at least 24 hours notice. (You can leave a message with the answering service during non-business hours). Otherwise, you will be billed $25.00 which is not covered by insurance and which must be paid before another appointment is scheduled.

INSURANCE COVERAGE

Your insurance coverage is a contract between you and your insurance company. Insurance forms will be filed on your behalf to your insurance company. However, this does not relieve you of your financial responsibility.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISCELLANEOUS FEES

The charge for completing medical forms (disability, leave of absence, etc.) is $10.00 to $15.00. Forms will be completed as time permits usually within one week.

Copies of medical records are available at $0.50 per page.
Copies of digital x-rays (taken in this office)- $5.00 for a CD and $5.00 per page for a hard copy.

All returned checks will be assessed an additional charge of $30.00 per check.

I HAVE READ THIS POLICY. I UNDERSTAND AND AGREE TO ITS' TERMS.

_____ _____

Signature Date

IRREVOCABLE ASSIGNMENT,
LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND AUTHORITY

To Whom It May Concern:

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Dr. Michael J. Liberman, Liberman Chiropractic 2301 Evesham Road, Suite 302, Voorhees,, NJ 08043. (856-770-1313) such sums as may be due and owing this Office for services rendered me, both buy reason of accident or illness, and by reason of any other bills that are due this Office, and to withhold such sums from any disability benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event of my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payments upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or I the Office's name and further I authorize to compromise, settle, or otherwise resolve said claim or cause of my action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to my insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, and Authorization. I agree that the above-mentioned Office be given Power of Attorney to endorse/sign my name and any and all checks for payment of my doctor bill.

Name:_____
Please print

Address:_____
_____
_____

Signed:_____ Date:_____

Witness:_____ Date:_____