Asheville Pain and Wellness Center

Chiropractic Care for Every Body!

Dr. Terri Lechner, D.C., P.A.

NEW PATIENT REGISTRATION & CASE HISTORY

Date: _____ **Patient Title:** ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss** ☐ **Dr.**

First Name: _____ **Last:** _____

Middle: _____ **Suffix:** _____ **Nick Name:** _____

Address: _____

City: _____ **Home Phone:** (_____)_____

State: _____ **Zip:** _____ **Work Phone:** (_____)_____

E-mail Address: _____ **Cell Phone:** (_____)_____

Contact Method: ☐Home phone ☐Cell Phone ☐Work Phone ☐Email

Birthdate:____/____/_____ **Age:** _____ **Height:** _____**Weight:**_____ **Gender:** ☐Male ☐Female

Race (mark all that apply):

☐ White ☐ Asian ☐ Native Indian/Alaskan Native ☐ I choose not to specify

☐Black/ African American ☐ Hispanic/ Latino ☐ Native Hawaiian/ Pacific Islander ☐Other_____

Preferred Language (check one):

☐ English ☐ Chinese ☐ German ☐ Other_____

☐Spanish ☐ Korean ☐ Russian ☐ I choose not to specify

☐ Japanese ☐ French ☐ American Sign Language

Marital Status: ☐Single ☐ Married ☐ Divorced ☐Widow(er) ☐ Partnership **Number of Children** _____ **Ages:** _____

Employment: ☐ Employed ☐ FT Student ☐ PT Student ☐Other ☐ Retired **Employer:** _____

Job Description_____ **Activities at work:**_____

If student please name school:_____

S.S.#:_____/_____/_____ **Driver's License Number:**_____ **State:** _____

Emergency Contact: _____ **Relationship:**_____ **Phone:**(____)_____

What is your chief complaint?_____When did this complaint begin?_____

What caused this problem?_____Complaints/Disturbances: ☐ Come and go ☐ gradually ☐ suddenly

Symptoms are **BETTER** in: ☐A.m. ☐ P.m. Symptoms are **WORSE** in: ☐ A.m. ☐ P.m.

Symptoms have persisted for: ☐ Hours ☐ 1 Day ☐ Days ☐ Weeks ☐ Months ☐ Years

Symptoms developed from ☐ A Work Related Injury ☐ An Auto Accident ☐ Other (Explain)_____

If in an **Auto Accident**, what was the date of your auto accident? _____ Were you wearing a seat belt? ☐ Yes ☐ No

Please describe what happened during the collision:_____

What was the speed of your vehicle?_____ What was the speed of the vehicle that hit you?_____

Was the vehicle you were in hit from the: ☐ Rear ☐ Front ☐ Side

Did you go to the hospital? ☐Yes ☐No If **yes**, list which hospital_____

Do you have any pain across your chest from the seat belt? ☐Yes ☐ No Did your airbag deploy? ☐Yes ☐No

In the accident, did you hit the dash board, steering wheel and/or airbag? ☐Yes ☐ No If **yes**, explain?_____

Were you knocked unconscious during the accident? ☐Yes ☐ No If **yes**, please explain_____

Have you suffered any bruising or other abrasions as a result of this accident? ☐Yes ☐ No

If **yes**, have you taken any photos? ☐Yes ☐ No Please indicate where you have bruising_____

Have you missed any time off work because of the auto accident? ☐Yes ☐ No Please list dates:_____

Specifically describe the type of pain you are having (dull ache, throbbing, shooting, burning, tingling, or numbness) **and rate the pain from 1 to 10** (1 indicating no pain and 10 indicating severe pain).

Involving neck, head and shoulders:_____

_____Rate your pain_____

Is your pain radiating down your arm? ☐Yes ☐ No Which one: ☐Right ☐ Left ☐Both

Involving low back/hips/legs and feet: _____

_____Rate your pain_____

Is your pain radiating down your leg? ☐Yes ☐ No Which one: ☐Right ☐ Left ☐Both

Other health complaints: _____

_____Rate your pain_____

What activities make condition(s) WORSE? _____

What activities make condition(s) BETTER? _____

Have you ever had this condition/problem before? ☐ Yes ☐ No If yes, when? _____

Medications: **If none check here:** ☐

	Medication:	Dosage:	Frequency:	Form:	Method:	Started:	What It's For:
1.							
2.							
3.							
4.							

Medication Allergies: **If none check here:** ☐

	Medication:	Reaction:	Date Started:
1.			
2.			
3.			
4.			

When did you last see a doctor? _____

What was the purpose of that visit? _____

Have you seen a doctor for your current condition? ☐ Yes ☐ No If **yes**, who did you see? _____

Has any doctor diagnosed you with Hypertention presently? ☐ Yes ☐ No If **yes**, list doctors name: _____

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No If **yes**, what kind: ☐ Type I ☐ Type II

If **yes** to diabetes, was your lab work test for hemoglobin A1C > 9.0%? ☐ Yes ☐ No

May we obtain a copy of your A1C? ☐ Yes ☐ No List your managing doctor: _____

Have you had an X-ray, CT scan, or an MRI in the last 28 Days? ☐ Yes ☐ No If **yes**, what area of the body: _____

Family history (mark all that apply):

	Diabetes	Heart	Kidneys	Cancer	Back	Stroke	High BP
Mother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐

Women: Are you pregnant? ☐ Yes ☐No What was the date of your last menstrual cycle? _____

Check any of the following diseases you have had:

☐Aids/HIV ☐Alcoholism ☐Anemia ☐Appendicitis ☐Arthritis ☐Cancer ☐Chicken Pox ☐Diabetes ☐Diphtheria ☐Eczema ☐Epilepsy ☐Goiter ☐Heart Disease ☐Influenza ☐Malaria ☐Measles ☐Mental Disorder ☐Mumps ☐Pleurisy ☐Pneumonia ☐Polio ☐Rheumatic Fever ☐Scarlet Fever ☐Small Pox ☐Tuberculosis ☐Typhoid Fever ☐Venereal Infection ☐Whooping Cough

Muscles and Joints:
☐Low back pain ☐Pain between shoulders ☐Neck pain/stiffness ☐Arm/elbow/wrist pain ☐Walking problems ☐Difficulty chewing ☐Clicking jaw ☐Leg/Knee/Foot pain ☐Hip pain ☐Pain in Tailbone

Eye, Ear, Nose & Throat:
☐Vision problems ☐Dental problems ☐Sore throat ☐Earaches ☐Hearing difficulty ☐Stuffed nose ☐Ringing in ears ☐Nose bleeds ☐Sinus trouble ☐Swollen Glands

Heart & Lungs:
☐Wheezing ☐Chest pain ☐Asthma ☐Short breath ☐High Blood Press ☐Low Blood Press ☐Irregular heart beat ☐Heart surgery ☐Lung congestion ☐Coughing ☐Spitting up blood ☐Varicose veins ☐Ankle swelling ☐Bronchitis

Stomach/Intestines:
☐Poor appetite ☐Excessive appetite ☐Excessive thirst ☐Nausea ☐Vomiting ☐Diarrhea ☐Hemorrhoids/piles ☐Liver trouble ☐Gall Bladder trouble ☐Weight trouble ☐Stomach cramps ☐Stomach pain ☐Gas/bloating ☐Heartburn ☐Black/blood stool ☐Colitis ☐Poor digestion

Nervous System:
☐Nervousness ☐Numbness ☐Paralysis ☐Confusion ☐Cold/tingling in extremities ☐Fainting ☐Dizziness ☐Depression ☐Convulsions

Kidney/Bladder:
☐Painful urination ☐Excessive urination ☐Discolored urine ☐Bedwetting ☐Bad urine control

Men:
☐Prostate pain ☐Impotence ☐Infertility

Women:
☐Menses irregular ☐Menstrual cramps ☐Vaginal pain ☐Breast lumps ☐Pain during sex ☐Fertility Problems ☐Miscarriage

General Problems:
☐Fatigue ☐Night sweats ☐Frequent colds ☐Loss of Sleep ☐Fever ☐Headaches ☐Weakness

Do you currently use tobacco products of any kind? ☐ Yes ☐ Formerly ☐ Never

If **yes**, how often do you use: ☐ Currently everyday ☐ Currently some days

If **yes**, what is your interest in quitting? (1= not interested, 10 = very interested) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How often do you drink and amount of per week: Alcohol_____ Soda_____ Water_____

Payment Information:

Clinic policy requires payment arrangements be made on the first visit if any balance is due. How do you intend to handle this account?

☐ Cash/ Self Pay ☐ Health Insurance ☐ Medicare ☐ Medicaid / Title 19 ☐ Worker's Compensation ☐ Personal Injury / Auto Insurance

Signature of Patient:_____ **Date:**_____

Printed name of Parent/Guardian if patient is under the age of 18:_____

Signature of Parent/Guardian if patient is under the age of 18:_____