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 □ Hispanic □ Asian □ I choose not to specify

□ Black/ African American □ American Indian/Alaskan Native □ Native Hawaiian/ Pacific Islander □Other_____

Ethnicity (check one): □ Hispanic or Latino □ Not Hispanic or Latino □ I choose not to specify

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
- □Whopping 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:_____