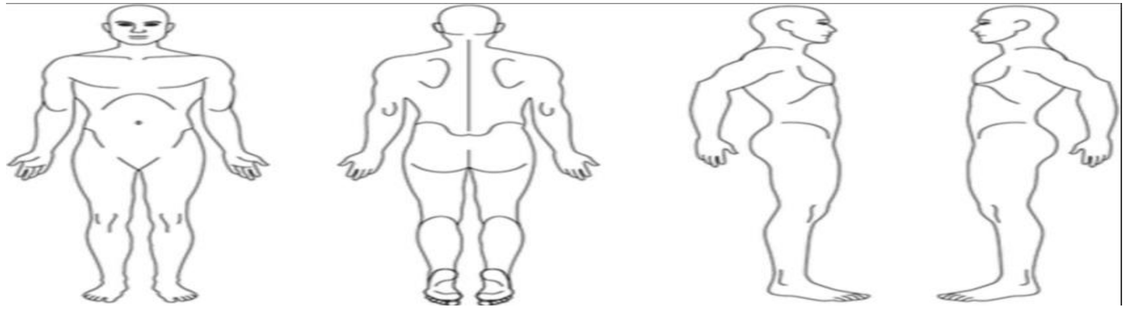
Patient's Name: ________________________________ Date: ________________

Draw where you have pain/restrictions



List your health concerns form greatest to the least starting from Column #1

	Most Pressing issue	2nd Most important	3rd Most important	4th Most important
Current Complaints List worst to least	1st ______________ ________________ Left Right Both	2nd ______________ ________________ Left Right Both	3rd ______________ ________________ Left Right Both	4th ______________ ________________ Left Right Both
Rate this problem on scale 0-----------10	0 1 2 3 4 5 6 7 8 9 10 0=No pain 10=Excruciating	0 1 2 3 4 5 6 7 8 9 10 0=No pain 10=Excruciating	0 1 2 3 4 5 6 7 8 9 10 0=No pain 10=Excruciating	0 1 2 3 4 5 6 7 8 9 10 0=No pain 10=Excruciating
How often do you feel this complaint?	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional	Constant Frequently Intermittent Occasional
When did this pain or restriction start?	___ Days ___Weeks ___ Months ___Years	___ Days ___Weeks ___ Months ___Years	___ Days ___Weeks ___ Months ___Years	___ Days ___Weeks ___ Months ___Years
Is this getting?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What have you done to take care of this Pain/Restriction?	MD, PT, Massage Ice/heat Stretch Rest Exercise Medications Other:	MD, PT, Massage Ice/heat Stretch Rest Exercise Medications Other:	MD, PT, Massage Ice/heat Stretch Rest Exercise Medications Other:	MD, PT, Massage Ice/heat Stretch Rest Exercise Medications Other:
Did it help?	Yes Partially No Slightly	Yes Partially No Slightly	Yes Partially No Slightly	Yes Partially No Slightly
Circle all that describes the quality of your complaint.	Dull Sharp Tingling Achy Burning Numb Stabbing Throbbing Stiff	Dull Sharp Tingling Achy Burning Numb Stabbing Throbbing Stiff	Dull Sharp Tingling Achy Burning Numb Stabbing Throbbing Stiff	Dull Sharp Tingling Achy Burning Numb Stabbing Throbbing Stiff
Does your pain Radiate if so, Where? i.e., arm Hand, Hip, Leg, Foot	________________ ________________	________________ ________________	________________ ________________	________________ ________________
Have you had this before? When?	________________	________________	________________	________________
How does this affect your daily life in the following areas? Grade 1-10 0=No pain 10=Excruciating.	___Work ___Sleep ___Bathing/Showering ___Dressing ___Cooking ___Cleaning ___Laundry ___Home maintenance ___Lawn Care ___Gardening ___Hobbies	___Work ___Sleep ___Bathing/Showering ___Dressing ___Cooking ___Cleaning ___Laundry ___Home maintenance ___Lawn Care ___Gardening ___Hobbies	___Work ___Sleep ___Bathing/Showering ___Dressing ___Cooking ___Cleaning ___Laundry ___Home maintenance ___Lawn Care ___Gardening ___Hobbies	___Work ___Sleep ___Bathing/Showering ___Dressing ___Cooking ___Cleaning ___Laundry ___Home maintenance ___Lawn Care ___Gardening ___Hobbies

Notes:____

Patient signature: ______________________________ Date: ________________ Reviewed: ________

Asheville Spine & Injury Center 16 Winterwind Drive Asheville, NC 28803 (P): 829.299.4555 (F) 828.229.7151

REGISTRATION

Name: ______________________________ Age: ______ Birthdate: ______________ Sex: M ☐ F ☐

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Occupation: __________________________
Address: ____________________________________City_____________ State______ Zip_________
Phone: ______________________________ Email: ______________________________________
Social Security #: ______________________
Person to contact in an emergency Name: __________________________ Phone #:____________
Insured's Name: ___________________________________

ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with ____________________________________ and assign directly to **Asheville Spine & Injury Center** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature: ____ **Date**: ____________

Present Complaints (Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: ____________________ **Medical alerts:** __________________
Surgical Implants: ____________________ **Pregnancy:** **yes** ___ **no** ___

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Smoking: ___ Yes ___ No If yes, _______ Packs per Day for ______ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _________

Personal Medical History & Review of Systems:

☐ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems
Please indicate with an "X" any medical problems that you currently have or have had in the past.

Lungs / Pulmonary – breathing disorders

- ☐ asthma
- ☐ COPD
- ☐ emphysema
- ☐ pulmonary embolism
- ☐ pneumonia
- ☐ tuberculosis
- ☐ respiratory arrest
- ☐ sleep apnea
- ☐ other: ____________________

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina
□ irregular heartbeat, arrhythmia
□ heart attack, myocardial infarction
□ heart murmur, valve disorder
□ peripheral vascular disease
□ congestive heart failure
□ mitral valve prolapse
□ deep vein thrombosis
□ bleeding problems
□ high blood pressure
□ Other ______________________

Neurologic Disorders

□ stroke or TIA
□ Parkinson's
□ cerebral palsy
□ peripheral neuropathy
□ MS □ polio
□ other: ______________________

Bone & Joint Disorders

□ osteoarthritis
□ rheumatoid arthritis
□ ankylosing spondylitis
□ osteomyelitis
□ gout □ lupus
□ other: ______________________

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer
□ diverticulitis
□ hepatitis - Type _______
□ acid reflux, GERD
□ irritable bowel
□ liver disease
□ GI bleed
□ inflammatory bowel disease
□ other: ______________________

Genitourinary Disorders

□ urinary tract infection
□ kidney problems
□ kidney stones
□ dialysis, kidney failure
□ bladder problems
□ other: ______________________

Metabolic & Other Disorders

□ tooth abscess, gingivitis
□ Diabetes x _________ years
□ skin disorder ________________
□ depression
□ anxiety
□ thyroid problems
□ psoriasis
□ skin ulcer
□ sickle cell disease
□ alcohol or drug dependency
□ high cholesterol or lipids
□ other: ______________________

Cancer : any type -- please specify ____

Other medical problems NOT included above (explain) ____
____

Family History: Please indicate with an "X" any significant family medical history or problems

□ asthma □ sleep apnea □ COPD
□ Emphysema □ tuberculosis
□ other lung:__________________
□ heart attack, myocardial infarction
□ congestive heart failure
□ irregular heartbeat, arrhythmia
□ bleeding problems
□ other heart :_____________
□ Peripheral neuropathy
□ sickle cell disease
□ MS or Parkinson's
□ other neuro :________________
□ osteoarthritis □ Lupus
□ gout □ rheumatoid arthritis
□ Other bone & joint: __________
□ acid reflux, GERD
□ hepatitis - Type ______
□ inflammatory bowel disease
□ liver disease
□ Malignant hyperthermia
□ other GI :___________________
□ kidney problems □ dialysis
□ diabetes
□ psoriasis □ skin ulcer
□ high cholesterol or lipids
□ thyroid problems
□ Cancer : type -- please specify

Other medical problems NOT included above (explain) ____

PATIENT INSURANCE INFORMATION: check any and all insurance coverage you or your spouse have in this case

□ Major Medical
□ Workman's Compensation
□ Auto Injury Insurance
□ Blue Cross Blue Shield
□ Medicare
□ Other

Insurance Identification #:______________________________ Medicare ID #:___________________________________

Major Medical or Auto Insurance Company Name: ____
Date of Accident: _________________ Adjuster: ____
Address: ____ Phone: ______________
Claim #: __________________________ Policy #: _____________________________ Effective Date: _________________

Primary Care Physician: Name & Address: ____Phone #: ____________
LEGAL INFORMATION: Attorney Name: _______________________ Phone #: _________________________________

*Person to contact in an emergency Name: _________________________ Phone #: ________________________________

Signature:____ **Date:**____________________

Name: ________________________ Date:_______________

Medications: *(Please list all medication and supplements that you currently take, or provide list to staff for copy)*

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Allergies: *(please list all medications that cause allergic reaction)*

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Surgical History: Please list ALL previous surgery and the date (approximately) it was performed:

Surgery ________________________________ Date _______________

Surgery ________________________________ Date _______________

Surgery ________________________________ Date _______________

Surgery ________________________________ Date _______________

Surgery ________________________________ Date _______________

Surgery ________________________________ Date _______________

Patient Signature:____________________________ Reviewed _________

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