

Rate your pain - how do you feel today?

On a scale from 0 to 10, with 0 representing no pain and 10 representing the most severe pain you can imagine, please circle the appropriate number on each scale.

How do you rate your pain today? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Since your pain started, how do you rate your least pain level? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Since your pain started, how do you rate your worst pain level? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

If this complaint was made worse by an auto accident, work or personal injury, what was your level of pain prior to the accident? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

If your primary complaint is a pain complaint, does it radiate? Yes No

If "Yes", it radiates to where? _____

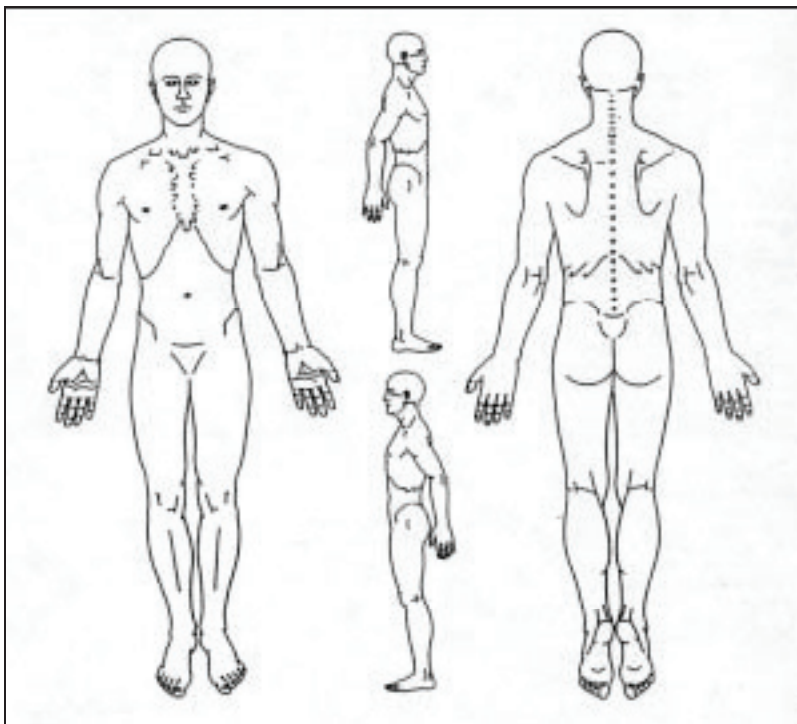
Is this your first episode of this pain complaint? Yes No

Have you had more than four episodes? Yes No

Is your primary complaint: Improving Getting worse About the same Intermittent

If your complaint is Auto, Work or Other-Accident related, when was the accident? _____/_____/_____

Please mark all areas of pain:



Patient information & authorization

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for

professional services rendered me are immediately due and payable unless other arrangements have been made.

I authorize 1st Choice Health & Wellness Center to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

Patient's signature

Date

Spouse's or Guardian's signature

Date