1ST Choice Health & Wellness Center

Patient Record

Date:___________________

Who referred you to us?

____

2441 State Street, #10 New Albany, Indiana 47150 (812) 945-4500

Name (first, middle initial, last): ____

Address:____

City:______________________________ State:________________ Zip:____________

Date of Birth: ______________ Age: ____________ Gender: ❏ Male ❏ Female Height: ______ Weight: ______

Marital status: ❏ Married ❏ Single ❏ Widowed ❏ Divorced Spouse's name: ______________________

# of Children: _Name(s)____

Social Security number: ______/_____/______ Home phone: ( ) ______________ Cell phone: ( ) ______________

Email: ______________________________ What is the best way to reach you?: ❏ Home ❏ Cell ❏ Work ❏ E-mail

Employer: ____________________________ Job title: ______________ Work phone: ( ) ____________ Ext_____

• *Insurance information - (Please also bring your insurance card(s) so we can put a copy in your file. Thanks!)*

Primary insurance company: ______________________ Insurance ID #: __________ Group/Claim number: __________

Name of insured: ____________________ Name of insured's employer: ________________ Phone: ( ) __________

Secondary insurance: ____________________ Insurance ID #: ____________ Name of insured: ________________

Who is responsible for this account?: ____________ Relationship to patient: ______________________

• *Emergency contact information - In case of emergency, who should we contact?*

Name (first, middle initial, last): ______________________________________ Relationship: __________

Phone number: ( ) ______________________________________ Cell phone: ( ) ______________________

• *Medical background information -*

What is your primary care doctor's name & address?: ______________________________________

Have you had medical problems with: ❏ Heart ❏ Lungs ❏ Kidneys ❏ Gastro-Intestinal ❏ Genital/Urinary
❏ Nervous system (seizures, depression) ❏ Endocrine (diarrhea) ❏ Skeletal

For women only - Are you now (or do you think you might be) pregnant?: ❏ Yes ❏ No ❏ Maybe

List all medications you are currently taking and the reason you are taking them: ______________________

____

____

____

List all medical allergies: ____

List all major surgeries and the approximate dates you've had them during your lifetime: ______________________

____

Do you smoke? ❏ Yes ❏ No Do you drink alcohol?: ❏ None ❏ Socially / occasionally ❏
Daily

• *Your current condition*

What is your major symptom/problem?:______________________________Date began?: ______________

What is the cause of your complaint?: ❏ Auto Accident ❏ Work injury ❏ Other Accident ❏ Illness ❏ Congenital ❏
Unknown Please describe how this onset of your primary complaint started:______________________________

____

____

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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

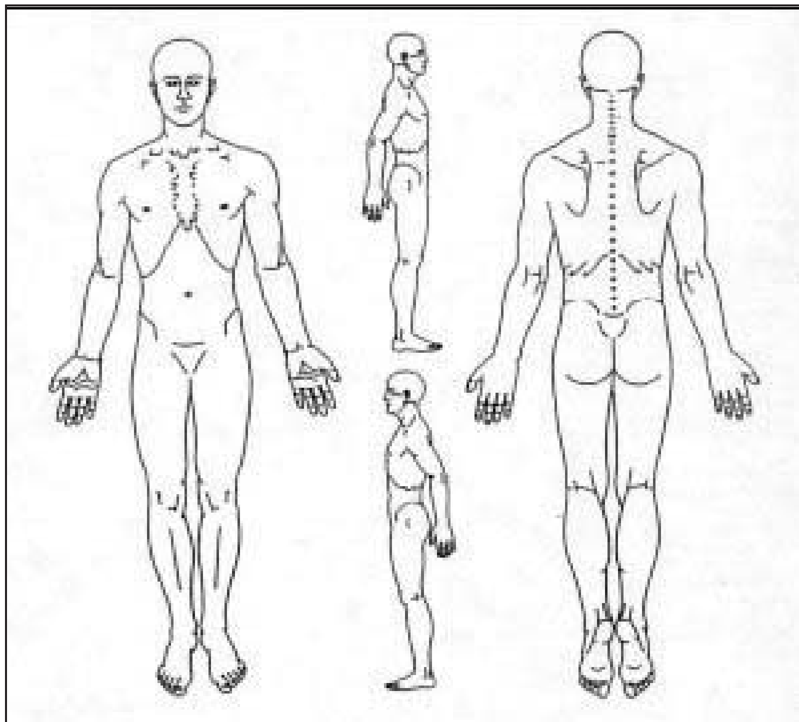
Have you had more than four episodes? ❑ Yes ❑ No

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