FIRST CHOICE HEALTH GROUP, INC.

1636 Lexington Avenue
Mansfield, OH 44907
Phone 419-756-3000
Fax 419-756-7747

Date:__________________

Patient Data:

Name:__________________________ Address:__________________ Apt. No._________
City:____________________________ State:____________ Zip Code:_____________
Home No.:__________________ Work No.:_______________ Cell No.:______________
Age:______ Date of Birth:___mo_____day____yr Married/Single/Widowed/Divorced
Social Security Number: ____________________________ Number of Children:_____
Occupation:_____________________________ Employer:_________________________
Employer Address: __________________________ Driver Lic. #: ___________________
Spouse Name: __________________________ Spouse Social Security No.:___________
Spouse Date of Birth:____mo_____day______yr Spouse Employer:_________________
Spouse Occupation:_______________________ Spouse Work No.__________________
Parent/Guardian: ________________________ Relation:_____________ Phone:______________
In the case of an emergency notify: ___________________ Phone No.______________
How did you hear about our office?: Yellow Pages Friend Sign in yard Flyer
Other, Please explain:____

Insurance Data:

Is insurance available for you? YES NO
Name of party responsible for primary insurance: ______________________________
ID of party responsible for primary insurance: _________________________________
Phone No. of party responsible for primary insurance:__________________________
Name of primary insurance company:____
Phone No. of primary insurance company:_____________________________________

Name of party responsible for secondary insurance: ____________________________
ID of party responsible for secondary insurance: _______________________________
Phone No. of party responsible for secondary insurance:________________________
Name of secondary insurance company: ______________________________________
Phone No. of secondary insurance company:___________________________________

Patient Agreement:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that 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 upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered 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, any fees for professional services rendered to me will be immediately due and payable.

Patient signature: ___________________________ **Date:**_______________

Legal Guardian's signature: _____________________ **Date:**______________

Present complaint:

Date of Injury:______________ Other doctors seen for this problem:___________________

Have you been hospitalized for this problem? YES/NO How many days:_______

Have you missed any work? If yes, how many days ?: _________________

Please circle any of the following that relate to the condition you are here for:

Anxiety	**Chest pain**	**Pain behind ears**	**Off balance**
Tension	**Irritable**	**Cold hands/feet**	**Head is heavy**
Fear	**Depression**	**Rib pain**	**Nausea/vomiting**
Fainting	**Constipated**	**Extreme fatigue**	**Swollen**_____________
Insomnia	**Nervousness**	**Mental dullness**	**Eyes sensitive to light**
Tremors	**Loss of taste**	**Mid back pain/stiffness**	**Dizziness**
Neck pain	**Loss of smell**	**Limited neck movement**	**Face flushed**
Diarrhea	**Double vision**	**Low back pain/stiffness**	**Loss of focus**
Headache	**Sinus trouble**	**Upper back pain/stiffness**	**Digestive problems**
Face pale	**Neck stiff**	**Excess perspiration**	**Numb fingers/toes**
Eye strain	**Memory loss**	**Shortness of breath**	**Pins/ needles arms/legs**
Jaw pain	**Legs fatigue**	**Ears ringing/buzzing**	**Head/shoulders tired**

It is difficult for me to: **STAND** / **WALK** / **RIDE FOR A LONG PERIOD** / **BEND** / **SIT** / **LAY**

The pain radiates into my: **LEGS** / **ARMS** / **HEAD** / **RIBS** / **SHOULDERS** / **FINGERS** / **TOES**

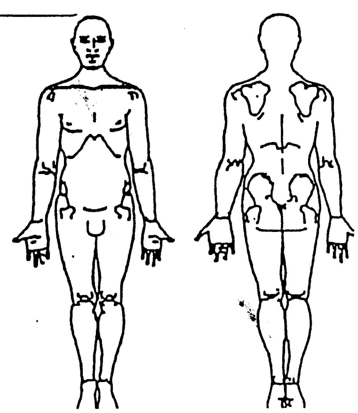
It is difficult for me to lift: **LIGHT** / **MODERATE** / **HEAVY** / **REPETITIVE**

I also have other symptoms: ____

____

Is there any medication you have taken or anything else you have done to relieve your pain? If yes, please explain: ____

Please indicate on the pictures by using lines, circles and dots where it hurts.



Is there anything else to be told about your injury?__________________

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Relevant Medical History:

Please circle what applies to you:

Arthritis	**Asthma**	**Anemia**	**Back pain or spasm**	**Cancer**
Concussion	**Convulsion**	**Diabetes**	**Digestion problems**	**Dizziness**
Epilepsy	**Fibromyalgia**	**Gout**	**German Measles**	**Hand/wrist pain**
Headaches	**Heart problem**	**Hepatitis**	**High blood pressure**	**HIV**
Kidney disease/stone	**Measles**	**Migraine**	**MS**	**MD**
Neck pain or soreness	**Nervousness**	**Neuritis**	**Numbness**	**Polio**
Rheumatic Fever	**Sinus Trouble**	**Sciatica**	**Spinal Operation**	**Stroke**
TB	**Ulcer**	**Venereal Disease**		

Please list and date past surgeries, traumatic injuries or psychiatric illnesses:

____

____

Have you been treated by a physician for any condition in the last 12 months? YES/NO
If yes please describe: ____

Have you ever had a physical? YES/NO If yes, when was the last one?______________

Please list any medications you have taken in the last 60 days: ___________________

____

____

Please list any allergies, including allergies to medications:

____

____

Please circle the following that pertain to you:

Exercise daily	**Drink alcohol occasionally (1-2 times per week)**
Exercise 3-5 times per week	**Drink alcohol more than one time per day**
Work up to 40 hours per week	**Smoke cigarettes, cigars, pipe etc.**
Work over 40 hours per week	**Drink caffeinated products daily**
Sleep 8-10 hours per day	**Eat regular meals 2-3 per day**

Please list your **Family Physician:** ______________________________

FEMALES ONLY:
To my knowledge, I am not pregnant. **Name**____________________ **Date**__________