Name _____ DOB _____AGE____Phone _____
Address_____ City _____ State _____ Zip _____
Employer's Name _____ Employer's Address _____
Were there any witnesses? ( ) Yes ( ) No Name(s)_____

Nature of Accident:

1. Date of Accident: _____Time of Day _____Seat Belt ( ) On ( ) Off
2. Weather: Rain/ Snow/Sunny/Poor visibility. Road Conditions: Wet/ Dry/ Icy
3. Year, Make Model of your vehicle_____

4. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
5. Air bag deployed ( ) Yes ( ) No, If yes ( ) front ( ) side
6. Were you struck from:( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Estimated speed of the vehicle you were in____ Estimated speed of other vehicle____
8. Head rest position ( ) High ( ) Middle ( ) Low
9. Position of your head ( ) Forward ( ) Left ( ) Right
10. Were you aware of the impending Collision/did you see it coming ( ) Yes ( ) No
11. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long? ____
12. Were police notified? ( ) Yes ( ) No
13. Where were you taken after the accident? ( ) Home ( ) Hospital, By Ambulance Y/N
Hospital Name_____
Treatment at Hospital X-rays/MRI/CT, Body parts_____
Medication given_____
_____
Admitted; ( ) No ( ) Yes for how long_____ For what condition_____
_____
14. In your own words, please describe accident: _____
_____
_____
_____
_____
_____
_____
15. Did you have any physical complaints BEFORE THE ACCIDENT? ( )Yes ( ) No
If yes, please describe in detail: _____
_____
_____

16. Please describe how you felt:
a. IMMEDIATELY AFTER the accident: _____
_____
_____
_____

17. What are your PRESENT complaints and symptoms? _____
_____
_____
_____
_____

18. Do you have any congenital (from birth) factors which relate to this problem?
( ) Yes ( ) No. If yes, please describe: _____
_____

19. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
If yes, please describe: _____
_____

20. Have you ever been involved in an accident before? ( ) Yes ( ) No. If yes, please describe, including date(s) and type(s) of accidents, as well as injuries received. _____
_____
_____

21. Have you ever been treated by another doctor since the accident? ( ) Yes ( ) No.
If yes, please list doctor's name and address: _____
_____
_____
_____
_____

22. What type of treatment did you receive _____
_____
_____

23. Were you given any supplies or devices to use at home? Ice pack/heat pack/traction/ electrical stim unit/ support belts etc;_____

24. Since this injury occurred, are your symptoms:
( ) Improving ( ) Getting Worse ( ) Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache ☐ Irritability ☐ Numbness in Toes ☐ Face Flushed
☐ Feet Cold ☐ Neck Pain ☐ Chest Pain ☐ Shortness of Breath
☐ Buzzing in Ears ☐ Hands Cold ☐ Neck Stiff ☐ Dizziness ☐ Fatigue
☐ Loss of Balance ☐ Stomach Upset ☐ Sleeping Problems
☐ Head seems Too Heavy ☐ Depression ☐ Fainting ☐ Constipation
☐ Back Pain ☐ Pins & Needles in Arms ☐ Lights Bother Eyes
☐ Loss of Smell ☐ Cold Sweats ☐ Nervousness
☐ Pins & Needles in Legs ☐ Loss of Memory ☐ Loss of Taste ☐ Fever
☐ Tension ☐ Numbness in Fingers ☐ Ears Ring
☐ Diarrhea

Symptoms Other Than Above _____

25. Have you lost time from work as a result of this accident? ( ) Yes ( ) No.
Time missed_____

a. If you are out of work please state last day worked _____

b. Type of Employment: _____

26. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No.

If yes, please describe, in detail: _____

_____

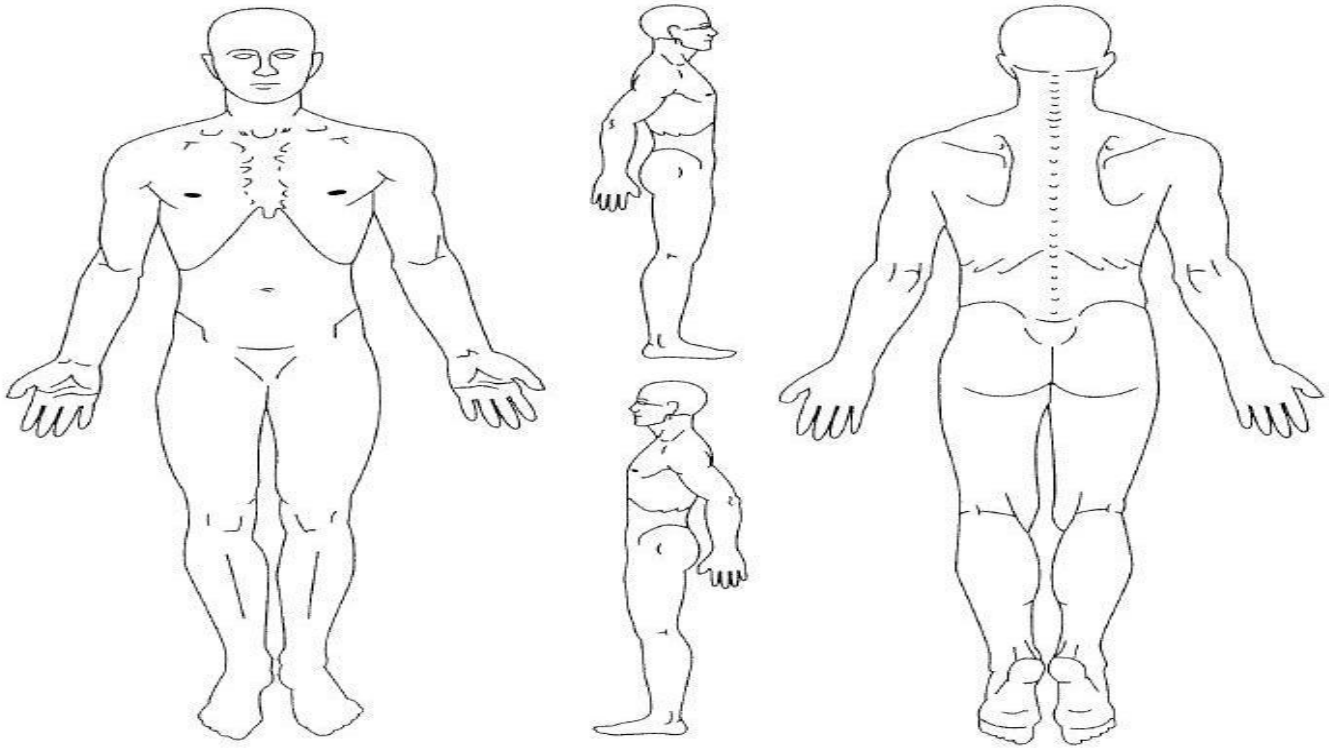
_____

_____

_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

When did your symptoms begin? _____

Does anything improve your pain? Yes No **If Yes, please list:**_____

_____

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp ☐ Ache ☐ Numb ☐ Shooting

☐ Burning ☐ Tingling ☐ Throbbing ☐ Other _____

25. Any other pertinent information:

_____

_____

_____
_____
_____
_____
_____

Patient Signature_____ Date _____

Assignment of insurance benefits

Patient Name:

I authorize and direct that payment be made directly to:

Atlanta Spine & Sport
3719 Old Alabama Rd.
STE. 400 A
Alpharetta GA, 30022

For any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

_____ _____
Date Patient Signature

RELEASE OF INFORMATION. I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan of Medicare.

_____ _____
Date Patient Signature

PAYMENT AGREEMENT. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

_____ _____
Date Patient Signature