Spring Spine Center Date:_____

Name:_____ SSN:_____

DOB:_____ Age:_____ Gender: **M / F** Marital Status: **S M D W**

Address:_____ City:_____ State:_____ Zip:_____

Home #:_____ Cell:_____ Email:_____

Occupation:_____ Employer:_____ Work #:_____

Emergency Contact:_____ Cell:_____ Relationship to patient:_____

Primary Care Physician: _____ How did you hear about us: _____

Injury Information

Date / Time of accident: _____ **AM / PM** Type of Accident: **Auto Work Other**:_____

Give a full description of how **Accident / Injury** happened: _____

_____

Did you go to the **Doctor / Hospital** after your injury? **YES** please list**:** _____ **No**

Attorney:_____ Phone:_____

Current Complaints

Describe your symptoms:_____

When did your symptoms begin:_____ Have you had similar symptoms in the past? **Y / N**

How did your symptoms begin? **Work Auto Accident Other** (describe):_____

Progression: **Improving Not-improving Worsening** What makes it worse: _____

Describe: **Sharp Shooting Achy Burning Numb Tingling** What makes it better: _____

How severe are the symptoms on a scale of 1-10: **None** - 1 2 3 4 5 6 7 8 9 10 – **Worst**

Acknowledge of Review of Notice of Privacy Practices

I, _____, (print name) confirm I have received and reviewed the Notification of Privacy Practices for Spring Spine Center as required by law. I confirm that a copy of this notice has been provided for me.

_____ _____

Patient/Legal Guardian Signature Date

The undersigned patient hereby acknowledges that he/she is seeking medical care and treatment from Spring Spine Center and that the doctor will rely on the patient for giving truthful statements regarding the facts and circumstances surrounding his/her illness and/or injury. Any untruthful statements can possibly lead to the rendering of an improper diagnosis and/or unnecessary treatment. I, the patient, therefore attest that the questions responded to above are truthful and accurate.

_____ _____

Patient/Legal Guardian Signature Date