THE SPINE CENTER

GET BACK TO LIFE

1130 Beltline Road
Suite 135
Garland TX 75040
(972) 530-9933
Fax(972) 530-9004

R. DAVID BAUER, M.D.

Dear New Patient;

Please read the following instructions carefully. We strive to provide the best care possible. However, if we do not have all the information necessary, it may become necessary to reschedule your appointment. We do not wish to do this, so please help us take care of you.

Enclosed please find the forms you will need to have completed before your appointment with Dr. Bauer. **These forms are important** to get the most accurate history from you. To decrease the time you spend in our office, we must receive them in our office prior to your appointment date. If for some reason you are unable to complete these forms prior to your appointment please
contact our office so we can be of assistance. .

You will need to bring the following items with you:

1. If you have had performed any X-rays, MRI's, CT scans, Myelograms, EMG or any other diagnostic test**,**

   IT IS IMPORTANT TO BRING THESE FILMS AND THEIR REPORTS WITH YOU TO YOUR APPOINTMENT.

   It is vital that we see the original study, as well as the radiologist's or other doctor's interpretation. If you are unable to bring these films, please call the office so we can assist you.

2. Please bring your current insurance card or worker's compensation documents, along with picture ID.
3. Any medical records pertaining to your current health status.

If you are unable to bring the above items at your appointment time, your appointment may need to be re-scheduled in order to best serve you.

Enclosed is a map showing our location. Our facility is located in the Northstar Crossing Shopping Center at the intersection of Beltline Road and Brand Road in Garland.

We look forward to seeing you. Please do not hesitate to contact us if you have any questions or we can assist you. Thank you for trusting us with your care.

The Spine Center
R. David Bauer
1130 Beltline Rd. Suite 135, Garland, TX. 75040 (972)-530-9933

Office hours: M-TH. 8-5. Fridays 8-3
Telephones: M-TH 8:30-12:00 and 1:00-4:30. Fridays 8:30-3:00

PATIENT INFORMATION SHEET

DATE	NAME LAST	FIRST	MIDDLE (LEGAL)

HOME PHONE#	CELL PHONE#	EMERGENCY #	SEX	AGE	DATE OF BIRTH / /

ADDRESS	RACE	LANGUAGE	ETHNIC GROUP

CITY	STATE	ZIP CODE	SOCIAL SECURITY #

EMPLOYER	HOW LONG ?	OCCUPATION

ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE #

PRIMARY CARE PHYSICIAN

NAME:_____

ADDRESS:_____

REFERRING PHYSICIAN OR PATIENT

NAME: _____

ADDRESS:_____

SPOUSE OR PARENT (CIRCLE ONE)

NAME LAST,FIRST,MIDDLE	SOCIAL SECURITY #	OCCUPATION

EMPLOYER NAME & ADDRESS	WORK PHONE #

INSURANCE INFORMATION MEDICARE # _____ MEDICAID # _____ COPAY $_____

PRIMARY	INSURANCE COMPANY NAME PHONE ( )	I.D.#/POLICY	GROUP NO.	INSURED EMPLOYER
	INSURANCE ADDRESS	INSURED NAME		INSURED D.O.B.
	CITY STATE ZIP CODE	INSURED SSN		RELATION TO PATIENT

INSURANCE INFORMATION MEDICARE SECONDARY # _____

SECONDARY	INSURANCE COMPANY NAME PHONE ( )	I.D.#/POLICY	GROUP NO.	INSURED EMPLOYER
	INSURANCE ADDRESS	INSURED NAME		INSURED D.O.B.
	CITY STATE ZIP CODE	INSURED SSN		RELATION TO PATIENT

PHARMACY INFORMATION :

NAME:_____

ADDRESS:_____

_____

PHONE NUMBER:_____

A PHOTOSTAT COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the Garland Spine Center, to furnish my referring physician, insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign to the Garland Spine Center all money to which I am entitled for medical and/or surgical expense relative to the service reported herein, but not to exceed my indebtedness to said physician and surgeon. I understand I am financially responsible to said clinic for charges not covered by this assignment. My signature below will also serve as an authorization to consent to treatment.

SIGNATURE: _____ PARENT □ GUARDIAN□

SERVICES RENDERED ARE PAYABLE AT TIME OF APPOINTMENT

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Garland TX 75040
(972) 530-9933
fax (972) 530-9004

AUTHORIZATION TO RELEASE INFORMATION

(Please print or type)
Patient Name_____

Address_____Date of Birth_____

City, State, Zip _____Phone #_____

1. I hereby authorize_____to release information
2. from my medical record to R. David Bauer, M.D. Garland Spine Center, 1130 Beltline Road, Suite 135, Garland TX. 75040 for the purpose of _____

The specific information requested is: (check one)

a: Confined to records regarding admission and treatment for the following medical condition or injury:

_____on or about (Date)_____

b: Covering records from (Date)_____to (Date)_____

c: Confined to the following specific information_____

d: Entire Record

3. If the requested portion of the record contains information pertaining to drug or alcohol related diagnosis and treatment or contains HIV related information or information about mental health disorders, you must specifically Consent to the release of such information by signing one or more of the following:

_____I understand that if my records contain information concerning drug or alcohol related diagnosis and treatment, such information will be released pursuant to this consent form. .

_____I understand that if my records contain confidential HIV related information, such information will be released pursuant to this consent form. Confidential HIV related information or any information that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicated that a person has been exposed to HIV.

_____I understand that if my records contain information concerning the diagnosis of treatment of a mental health disorder such information will be released pursuant to this consent form

4. I understand that this consent can be revoked in writing at any time before the records are released. Unless I revoke this authorization in writing; it shall expire when the information is released in reliance upon this consent or under the following circumstances:

Dated, event or condition of expiration:_____

_____

Signature of Patient or Representative: _____Date_____

Relationship to Patient_____

Witness_____

PATIENT MUST CONSENT TO RELEASE ENTIRE CONTENTS OF A RECORD CONTAING HIV RELATED INFORMATION.

If the above named patient is a minor who does not have the legal right to consent to treatment, or has a legally appointed guardian, this release must be signed by hi/her parent or guardian.

R. DAVID BAUER, M.D., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____ acknowledge that I have recieved a copy of R. DAVID BAUER, M.D., P.A. "Notice of Privacy Practices". This Notice describes how R. DAVID BAUER, M.D., P.A. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

(Signature of Patient, or Personal Representative) **(Date)**

(Relationship to Patient)

FORM# HIPAA/ACK Professional Office Systems, Inc.
2014

The Spine Center
R. David Bauer
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FINANCIAL POLICY

We are committed to providing you with both the best possible medical care and the very best in customer service. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Payment for services are due at the time services is rendered unless our staff has approved payment arrangements in advance. We accept cash, checks, Mastercard or Visa. We accept assignment of insurance benefits.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such at 50% or 80%) of "U.C.R ". "U.C.R." is defined as usual, customary and reasonable fees for this region.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- If your insurance company requires a written referral before an appointment with a specialist, you MUST present referral forms and/or referral numbers when checking in for your appointment. If you do not have this information we must either reschedule your appointment for a later date, or you must agree to be responsible for the entire cost of this visit.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Our filing of the insurance forms on your behalf does not relieve you of the final responsibility for settling your account.

If worker's compensation or automobile liability insurance does not pay on the account for any reason, you as the consumer of our services are responsible for payment in full. The financial obligation of a patient is not contingent on any settlement, claim, judgement or verdict that may be recovered. If there is no recovery, or recovery is incomplete, you are responsible for the debt that you incur. We will work with you in any way possible to assist in settling that debt.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. **We are here to help you.** A copy of this form will be made available to you if you wish.

SIGNATURE: _____ **DATE:** _____

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WHAT MEDICATIONS YOU ARE ALLERGIC TO?

TYPE/NAME OF MEDICATION	REACTION

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDE DOSAGE & FREQUENCY (INCLUDE ORAL CONTRACEPTIVES AND HERBAL MEDICATIONS):

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBING DOCTOR

SIGNATURE_____DATE_____

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MEDICAL AND SURGICAL HISTORY

PLEASE TELL US IF YOU IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING PROBLEMS?

ALLERGIES	Y	N	GALL BLADDER	Y	N	SKIN DISORDER	Y	N
ANXIETY ATTACKS	Y	N	GOUT	Y	N	COPD	Y	N
HAYFEVER	Y	N	STOMACH ULCER	Y	N	OBESITY	Y	N
ARTHRITIS	Y	N	HEART DISEASE	Y	N	STRESS DISORDER	Y	N
ASTHMA	Y	N	HEPATITIS	Y	N	STROKE	Y	N
BLADDER PROBLEMS	Y	N	HIGH BLOOD PRESSURE	Y	N	THYROID	Y	N
BLEEDING DISORDER	Y	N	IMMUNOLOGICAL DISORDER	Y	N	TUBERCULOSIS	Y	N
BLOOD DISEASE	Y	N	KIDNEY STONES	Y	N	VARICOSE VEINS	Y	N
DIABETES	Y	N	LIVER DISEASE	Y	N	VENEREAL DISEASE	Y	N
EMOTIONAL PROBLEMS	Y	N	PARATHYROID	Y	N	OTHER:	Y	N
EPILEPSY	Y	N	PROSTATE PROBLEMS	Y	N	SPECIFY_____		
FIBROMYLAGIA	Y	N	SEIZURE DISORDER	Y	N	SPECIFY_____		
CANCER	Y	N	TYPE_____					

PLEASE LIST ANY SPINAL SURGICAL PROCEDURES & DATE:

TYPE OF SPINE SURGERY	DATE:	SURGEON'S NAME	PHONE NUMBER

PLEASE LIST ANY MAJOR SURGICAL PROCEDURES & DATE

TYPE OF SURGERY	

FAMILY HISTORY:

ALCOHOLISM	Y	N	CATARACTS	Y	N	LEUKEMIA	Y	N
ALZHEIMERS	Y	N	DIABETES	Y	N	OBESITY	Y	N
ANEURYSMS	Y	N	HEART DISEASE	Y	N	SCHIZOPHRENIA	Y	N
ARTHRITIS	Y	N	HYPERTENSION	Y	N	STROKE	Y	N
BLEEDING DISORDERS	Y	N	KIDNEY DISEASE	Y	N	SUBSTANCE ABUSE	Y	N
CANCER	Y	N	TYPE_____			SUICIDE	Y	N

DO YOU SMOKE? _____ <1 PACK_____ 1-2 PACKS_____ 3 OR >_____ NUMBER OF YEARS SMOKED_____

DO YOU USE OTHER TOBACCO PRODUCTS? _____ DAILY USAGE_____ NUMBER OF YEARS USED_____

DO YOU DRINK ALCOHOL OR BEER? _____ DAILY_____ SOCIAL_____ OCCASIONALLY_____ NEVER_____

DO YOU USE RECREATIONAL/ ILLIGAL DRUGS? _____ TYPE?_____ USAGE_____

SIGNATURE_____DATE_____

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Are you on or planning to apply to any of the following programs? (Please circle "yes" or "no".)

	Already on it		Applied for it		Planning to apply	
Social Security	Yes	No	Yes	No	Yes	No
Disability	Yes	No	Yes	No	Yes	No
Worker's Compensation	Yes	No	Yes	No	Yes	No

Have you had a prior worker's compensation injury to your back or neck? Back Neck No

When?_____

Have you had a prior automobile accident with injury to your back or neck? Back Neck No

When?_____

PLEASE "BRING" YOUR DIAGNOSTIC FILMS

6. **What X-rays and tests have you had for the current pain? PLEASE PROVIDE FACILITY NAME/NUMBER**

DIAGNOSTIC PROCEDURES	√	FACILITY NAME	PHONE NUMBER
Regular X-ray			
CT SCAN			
MRI			
MYELOGRAM			
EMG/NCV			
BONESCAN			

SIGNATURE _____DATE_____

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SOCIAL HISTORY

What is your current marital situation?

a. Married How long? _____ years
b. Widowed How long? _____ years
c. Living with significant other How long? _____ years
d. Single (never married)
e. Divorced/Separated How long? _____ years

2. Do you have any children? Yes No
   How many? _____
   How old are they? _____

3. Do you have any grandchildren? Yes No
   How many? _____
   How old are they? _____

4. Do you live with someone who can take care of you (if needed)? Yes No

5. How much schooling have you completed?
   a. Less than high school
   b. G.E.D.
   c. Graduated from high school
   d. Some college
   e. Graduated from college
   f. Postgraduate school or degree

6. Which statements describe your current employment situation? (check all that apply)
   a. Currently working
   b. Homemaker
   c. Student
   d. On leave of absence
   e. Unemployed
   f. Retired (not due to ill health)
   g. Disabled and/or retired because of ill health
   h. Other, please specify

7. Where do you currently work? _____
   Date job started? Month _____ Day _____ 19_____
   Last date worked? Month _____ Day _____ 19_____

8. DO YOU SMOKE? _____ <1 PACK_____ 1-2 PACKS_____ 3 OR >_____ NUMBER OF YEARS SMOKED_____

9. DO YOU USE OTHER TOBACCO PRODUCTS? _____ DAILY USAGE_____ NUMBER OF YEARS USED_____

10. DO YOU DRINK ALCOHOL OR BEER? _____ DAILY_____ SOCIAL_____ OCCASIONALLY_____ NEVER_____

11. DO YOU USE RECREATIONAL/ ILLIGAL DRUGS? _____ TYPE?_____ USAGE_____

SIGNATURE: _____ **DATE:** _____

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INJURY HISTORY

HOW LONG HAVE YOU HAD THIS PAIN_____

1. **Are you here today due to a specific injury**? Y N
   If not, please skip down to #4
   If so, when did it occur?_____
   Was this a car accident? Y N
   Was this a worker's compensation injury? Y N

2**. Explain how the current injury occurred**?_____

_____

_____

_____

3. **What are your complaints since injury?**_____

_____

_____

4. **What health professionals have you seen for this pain**? **PLEASE PROVIDE PHYSICAN'S NAME/NUMBER**

Family doctor or internist?	Y	N	_____
Company Doctor?	Y	N	_____
Chiropractor?	Y	N	_____
Orthopedic surgeon?	Y	N	_____
Pain specialist?	Y	N	_____
Neurosurgeon?	Y	N	_____
Other Spinal surgeon?	Y	N	_____
Other Health provider?	Y	N	_____

5. **What treatment have you received for the current pain?**

Medications for current pain ……..	Y	N ____>>	Which?_____
Manipulations ? ……..	Y	N	
Physical therapy/exercise? ……..	Y	N ____>>	How many sessions?_____
Physical therapy/ TENS? ……..	Y	N	
Physical therapy/ultrasound? ……..	Y	N	
Brace? ……..	Y	N	
Epidural injections ? ……	Y	N	How many injections ?_____
			Date of injections ?_____
Facet injections ? ……	Y	N	
Surgery?	Y	N	

SIGNATURE _____DATE_____

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WITH THE FOLLOWING ACTIVITIES, IS YOUR PAIN:

With a cough or sneeze?	WORSE	BETTER	UNCHANGED
Sitting down at a table?	WORSE	BETTER	UNCHANGED
Sitting in an automobile? ……..	WORSE	BETTER	UNCHANGED
Bending forward to brush teeth? …….	WORSE	BETTER	UNCHANGED
Walking a short distance? ……	WORSE	BETTER	UNCHANGED
Lying flat on your back? ……	WORSE	BETTER	UNCHANGED
Lying flat on your stomach? ……	WORSE	BETTER	UNCHANGED
Lying on your side with your knees bent? ……..	WORSE	BETTER	UNCHANGED
Upon awakening in the AM? ……	WORSE	BETTER	UNCHANGED
Mid-morning? ……	WORSE	BETTER	UNCHANGED
Middle of the night? ……..	WORSE	BETTER	UNCHANGED

HAVE YOU EVER HAD COMPLICATIONS FROM ANESTHESIA? Y N

WHAT TYPE? _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? Y N

WHEN? _____

WHY?_____

SIGNATURE_____DATE_____

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NECK AND BACK QUESTIONNAIRE

In the **past month** (or since injury), how often have **you suffered:** (Please circle one.)

		None of the Time	A little of time	Some of the time	A good bit time	Most of the time	All of the time
1.	Neck pain?	0	1	2	3	4	5
2.	Arm pain?	0	1	2	3	4	5
3.	Numbness or tingling in arm and/or hand?	0	1	2	3	4	5
4.	Weakness in arm and/or hand?	0	1	2	3	4	5
5.	Low back and/or buttock pain?	0	1	2	3	4	5
6.	Leg pain?	0	1	2	3	4	5
7.	Numbness or tingling in leg and/or foot?	0	1	2	3	4	5
8.	Weakness in leg and/or foot?	0	1	2	3	4	5

In the **past month** (or since injury), how bothersome have these symptoms **been?** (Please circle one.)

		Not at all bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
9.	Neck pain.	0	1	2	3	4	5
10.	Arm pain.	0	1	2	3	4	5
11.	Numbness or tingling in arm and/or hand.	0	1	2	3	4	5
12.	Weakness in arm and/or hand.	0	1	2	3	4	5
13.	Low back and/or buttock pain?	0	1	2	3	4	5
14.	Leg pain?	0	1	2	3	4	5
15.	Numbness or tingling in leg and/or foot?	0	1	2	3	4	5
16.	Weakness in leg and/or foot?	0	1	2	3	4	5

In the **past month** (or since injury), please tell us **how pain has affected your ability to perform the following daily activities.** (Circle the **ONE** statement that best describes your average ability.)

17. Getting dressed (in the **past month**).
    a. I can dress myself without pain.
    b. I can dress myself without increasing pain.
    c. I can dress myself but pain increases.
    d. I can dress myself but with significant pain.
    e. I can dress myself but with very severe pain.
    f. Pain prevents me from dressing myself.
18. Lifting (in the **past month**).
    a. I can lift heavy objects without pain.

b. I can lift heavy objects but it is painful.
c. Pain prevents me from lifting heavy objects off the floor, but I can lift heavy objects if they are on a table.
d. Pain prevents me from lifting heavy objects, but I can lift light to medium objects if they are on a table.
e. I can only lift light objects due to pain.
f. I cannot lift anything due to pain.

19. Walking and running (in the **past month**).
a. I can walk or run without pain.
b. I can walk comfortably, but running is painful.
c. Pain prevents me from walking more than 1 hour.
d. Pain prevents me from walking more than 30 minutes.
e. Pain prevents me from walking more than 10 minutes.
f. I am unable to walk, or I can only walk a few steps at a time.

20. Sitting (in the **past month**).
a. I can sit in any chair as long as I like.
b. I can only sit in a special chair for as long as I like.
c. Pain prevents me from sitting more than 1 hour.
d. Pain prevents me from sitting more than 30 minutes.
e. Pain prevents me from sitting more than 10 minutes.
f. Pain prevents me from sitting at all.

21. Standing (in the **past month**).
a. I can stand as long as I want.
b. I can stand as long as I want but it gives me pain.
c. Pain prevents me from standing more than 1 hour.
d. Pain prevents me from standing more than 30 minutes.
e. Pain prevents me from standing more than 10 minutes.
f. Pain prevents me from standing at all.

22. Sleeping (in the **past month**).
a. I sleep well.
b. Pain occasionally interrupts my sleep.
c. Pain interrupts my sleep half the time.
d. Pain often interrupts my sleep.
e. Pain always interrupts my sleep.
f. I never sleep well.

23. Social and recreational life (in the **past month**).
a. My social and recreational life is unchanged.
b. My social and recreational life is unchanged but it increases pain.
c. My social and recreational life is unchanged but it severely increases pain.
d. Pain has restricted my social and recreational life.
e. Pain has severely restricted my social and recreational life.
f. I have essentially no social and recreational life because of pain.

24. Travelling (in the **past month**).
a. I can travel anywhere.
b. I can travel anywhere but it gives me pain.
c. Pain is bad but I can manage to travel over two hours.
d. Pain restricts me to trips of less than one hour.
e. Pain restricts me to trips of less than 30 minutes.
f. Pain prevents me from travelling.

25. Sex life (in the **past month**).
a. My sex life is unchanged.
b. My sex life is unchanged but causes some pain.
c. My sex life is nearly unchanged but it is very painful.
d. My sex life is severely restricted by pain.
e. My sex life is nearly absent because of pain.
f. Pain prevents any sex life at all.
g. The patient does not answer this question
h. The patient denies any sexual relation

MOTOR VEHICLE ACCIDENT FACT SHEET

1) Date of Accident? / /

2) Were you the:
   a) Driver
   b) Passenger in Front Seat
   c) Passenger in Back Seat
   d) Other

3) Were you in a:
   a) Car
   b) Pickup
   c) Van
   d) Large Truck
   e) 18-Wheeler
   f) Bus
   g) Jeep
   h) Suburban
   i) Motorcycle
   j) Other

4) Were you:
   a) Seat Belted
   b) Lap Belted
   c) Shoulder Belted
   d) Not Seat Belted
   e) No Seat belt Avail
   f) Seat belt did not work

5) Accident took place at a:
   a) Service road
   b) Intersection
   c) Highway
   d) Highway Entrance
   e) Highway Exit
   f) Slow traffic
   g) Road
   h) Stop sign
   i) Yield sign
   j) Parking lot
   k) Stopped traffic
   l) Other

6) The main vehicle you collided with was a:
   a) Car
   b) Pickup
   c) Van
   d) Large Truck
   e) 18-Wheeler
   f) Bus
   g) Jeep
   h) Suburban
   i) Motorcycle
   j) Other

7) Your vehicle was hit from:
   a) Rear
   b) Passenger's side
   c) Driver's side
   d) Left rear
   e) Right rear
   f) Left front
   g) Right front
   h) Was hit once
   i) Was hit twice
   j) spun around
   k) Vehicle flipped

8) Air bag?
   a) No Air Bag
   b) Air Bag opened
   c) Air Bag did not open

9) What broke in your vehicle?
   a) Windshield
   b) Side windows
   c) Steering wheel
   d) Head Light
   e) Seat
   f) Seatbelt
   g) Bumper

10) The damage to the vehicle you were in was:
   a) Minor
   b) Major
   c) Towed Away
   d) Car Totaled
   e) Don't know
   f) $_____

11) Who was at fault?
   a) Was my fault
   b) Others Fault
   c) Both our Fault
   d) Don't know
   e) I hit them
   f) they hit us
   g) Other

12) The other main vehicle Was
   a) Hit & Run
   b) Had NO Insurance
   c) Was Going at least _____ miles per hour

13) Including your vehicle how many vehicles were involved?
   a) One
   b) Two
   c) Three
   d) Multiple

14) Police Action:
   a) No Police involved
   b) Were called - did not come
   c) Came, NO report made
   d) Came, MADE Report

15) Ambulance Action
   a) No ambulance came
   b) Came - I was not checked
   c) Came - I was checked
   d) Took me to the hospital

16) Did you go to the hospital?
   Hospital Name: _____
   a) That day
   b) Next day
   c) Next week
   d) Much later

17) Did you see a doctor?
   Doctor's name: _____
   a) That day
   b) Next day
   c) Next week
   d) Much later

18) Street Where Accident Took Place: _____

19) City Where Accident Took Place: _____

20) Do you have a lawyer? Y N If so, whom? _____

21) Please give any other important details about the accident: _____

_____

SIGNATURE: _____ **DATE:** _____

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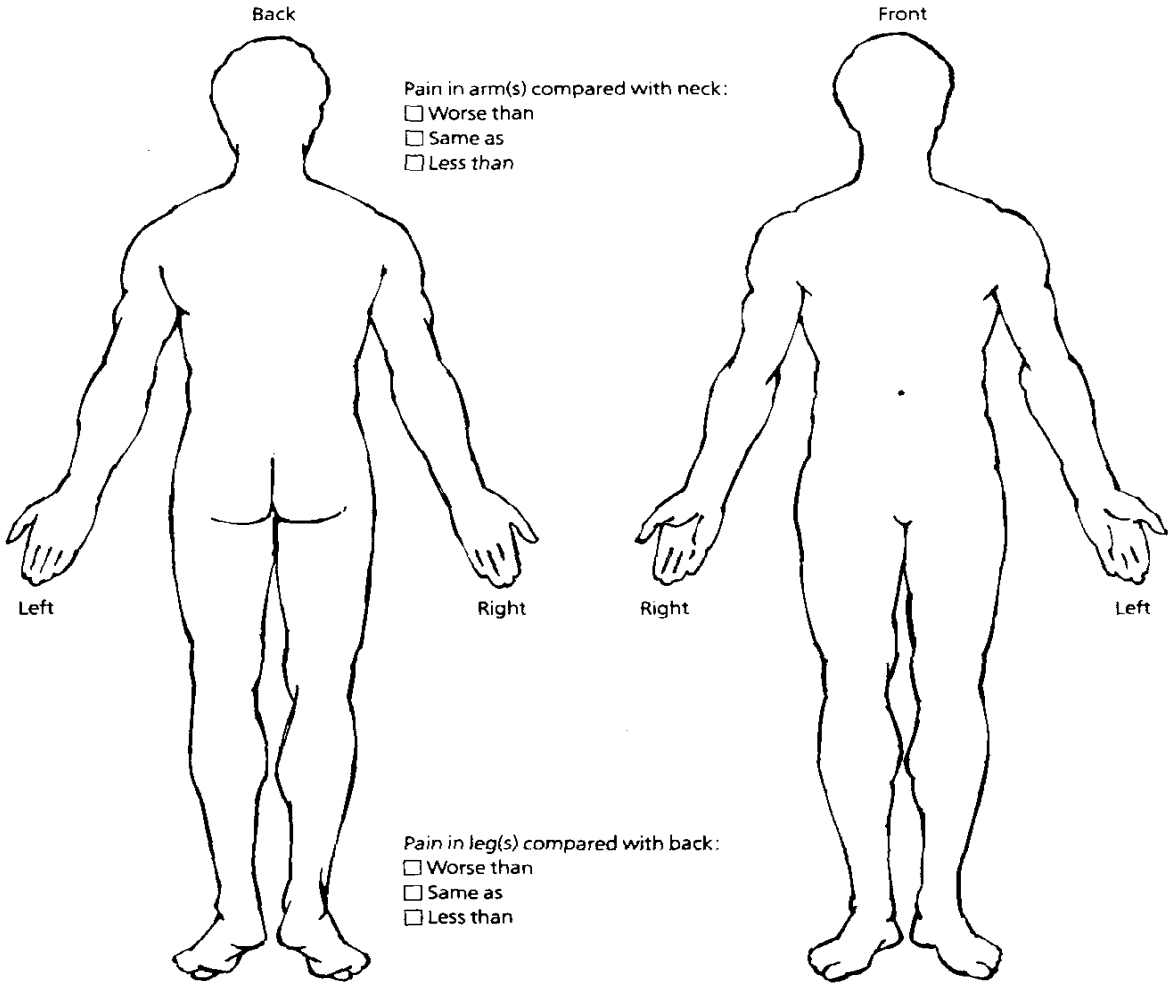
PATIENT PAIN DIAGRAM

1130 Beltline Road
Suite 135
Garland TX 75040
(972) 530-9933
Fax(972) 530-9004

Name: _____ Date: _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing	Other
▲ ▲ ▲	= = =	O O O	x x x	///	● ● ●



Pain in arm(s) compared with neck:
☐ Worse than
☐ Same as
☐ Less than

Pain in leg(s) compared with back:
☐ Worse than
☐ Same as
☐ Less than

On this line, indicate how severe is your pain today?

NO PAIN MODERATE PAIN EXTREME PAIN