ATLAS CHIROPRACTIC & MASSAGE THERAPY

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VEHICLE ACCIDENT INFORMATION

In addition to the **Confidential Health History** form you just completed, please take the time to complete this form as well. This will give the Doctor more information about your condition and how to treat it.

PATIENT INFORMATION

Full Name: _____ Date: _____

Date of Accident: _____ Time of Accident: _____

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: □ Driver □ Front Passenger □ Rear Passenger □ Pedestrian

How many people were in the accident vehicle?: _____

ACCIDENT INFORMATION

ACCIDENT SITE

Road/Street name: _____

City/Province: _____

Nearest Intersection: _____

Driving Conditions: □ Dry □ Wet □ Icy □ Other:_____

Which direction were you headed?:_____

Speed you were traveling?:_____

VEHICLE

Make and Model of the vehicle you were in:

_____

Were you wearing a seatbelt?: □ Yes □ No

Was vehicle equipped with airbags?: □ Yes □ No

If yes, did they inflate properly?: □ Yes □ No

Did your seat have a headrest?: □ Yes □ No

If yes, what was the position?: □ Low □ Mid □ High

IMPACT

Did your car impact another vehicle?: □ Yes □ No

Did your car impact a structure?: □ Yes □ No

If yes, explain: _____

Did any part of your body strike anything in the vehicle?:

□ Yes □ No If yes, explain: _____

Was impact from:

□ Front □ Rear □ Left □ Right □ Other: _____

At the time of the impact were you:

□ Looking straight ahead □ Looking to the right

□ Looking to the left □ Looking down

□ Looking up

Were both your hands on the steering wheel?: □ Yes □ No

If no, which hand was on the wheel?: □ Right □ Left

Was your foot on the break?: □ Yes □ No

If yes, which foot was on the break?: □ Right □ Left

OTHER VEHICLE (if applicable)

Make and model of other vehicle?: _____

Which direction was the other vehicle headed?: _____

Speed other vehicle was traveling: _____

POLICE

Did the Police come to the accident site?: □ Yes □ No

Were there any witnesses?: □ Yes □ No

Was a police report filed?: □ Yes □ No

Was a traffic violation issued?: □ Yes □ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident?: □ Yes □ No If yes, for how long?: _____

Please describe how you felt immediately after the accident. _____

_____

_____

_____

TREATMENT

Did you go to the hospital?: □ Yes □ No

If yes, when did you go?: □ Immediately after the accident □ Next day □ 2 days or more after the accident

How did you get to the hospital? □Ambulance □Private transportation

Name of hospital: _____ Name of Doctor: _____

Diagnosis: _____

_____

Treatment received: _____

_____

X-rays taken?: _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? □ Yes □ No How many days have you missed? _____

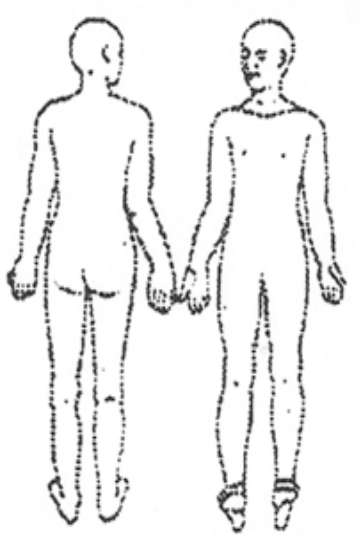
Prior to the injury were you able to work on an equal basis with others your age? □ Yes □ No

If you have had any of the following symptoms since your injury, please **X** all that apply.

□ Arm/shoulder pain
□ Back pain
□ Back stiffness
□ Chest pain
□ Dizziness
□ Ear buzzing
□ Ear ringing
□ Fatigue
□ Feet/toe numbness
□ Hand/finger numbness
□ Headaches
□ Irritability
□ Jaw problems
□ Leg pain
□ Memory loss
□ Nausea
□ Neck pain
□ Neck stiff
□ Shortness of breath
□ Sleep difficulty
□ Stomach upset
□ Tension
□ Vision blurred

Is the condition getting progressively worse? _____

Mark an **X** on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

If you are experiencing pain, is it…

□ Sharp □ Dull □ Throbbing □ Numbness
□ Aching □ Shooting □ Burning □ Tingling
□ Cramps □ Stiffness □ Swelling □ Other: _____

How often do you have this pain?: _____

Is it consistent or does it come and go?: _____

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements which are painful to do: □ Sitting □ Standing □ Bending □ Walking □ Lying down

I certify that the above information is correct to the best of my knowledge.

Patient's/Guardian's Signature: _____ Date: _____