DR. DENNIS W. HARDING D.C., B.C.A.O.
ATLAS SPECIALIST

11899 Edgewood Road, Suite D
Auburn, CA 95603
Ph: 530-823-3734
Fax: 530-823-5432
www.atlasdr.com

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name _____

Date of Accident _____ Time of Accident ❑ a.m. ❑ p.m.

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 SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ❑ Dry ❑ Wet ❑ Icy ❑ Other _____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ❑ Yes ❑ No

If yes, what type? ❑ Lap ❑ Shoulder

Was vehicle equipped with airbags? ❑ Yes ❑ No

If yes, did it/they inflate properly? ❑ Yes ❑ No

Did your seat have a headrest? ❑ Yes ❑ No

If yes, what was the position of the headrest?

❑ Low ❑ Midposition ❑ High

OTHER VEHICLE (if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

ACCIDENT SITE

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 impact were you:

❑ Looking straight ahead ❑ Looking to the right

❑ Looking to the left ❑ Looking down

❑ Looking up

Were both hands on the steering wheel?

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

Was your foot on the brake? ❑ Yes ❑ No

If yes, which foot was on the brake? ❑ Right ❑ Left

Were you: ❑ Surprised by impact ❑ Braced for impact

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

When did you go? ❑ Immediately after 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 work 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 check:

❑ 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 this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

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)_____

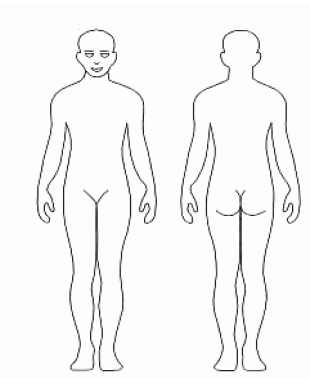
Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness
❑ Aching ❑ Shooting ❑ Burning ❑ Tingling
❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

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

Movements that are painful to perform: ❑ Sitting ❑ Standing ❑ Walking
❑ Bending ❑ Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor is I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient