ATLANTA SPINE CENTER

AUTOMOBILE ACCIDENT HISTORY

Patient Name _____ Todays Date _____ Date of Injury_____

Was the accident on the job? ◯Yes ◯No

Where were you seated in the vehicle? _____

Name of person driving the vehicle _____

Your Vehicle (year, make, model) _____

Your estimated speed at the moment of the accident _____ ◯Stopped ◯Slowing ◯Accelerating

If stopped, was your foot on the brake ◯Yes ◯No

Other Vehicle (year, make, model) _____

Estimated speed of the other vehicle at moment of impact _____ ◯Stopped ◯Slowing ◯Accelerating

Road conditions at the time of the accident:

◯Dry ◯Damp ◯Wet ◯Snow ◯Ice

Time of day:

◯Daylight ◯Dawn ◯Dusk ◯Dark

Head restraints, Seat backs:

How far is the top of the headrest or seatback from the back of your head? _____ inches

If adjustable, was the position of the headrest altered by the accident? ◯Yes ◯No

Was the seat back adjustment altered by the accident? ◯Yes ◯No

Was the seat boken ◯Yes ◯No

Seat belts and Air bags:

Were you wearing a seatbelt? ◯Yes ◯No ◯Don't know

What type? ◯Lap seat belt ◯Shoulder seat belt ◯Shoulder-lap seat belt

Did your air bag deploy? ◯Yes ◯No

If yes, were you struck? ◯Yes ◯No Where? _____

Head and Body position:

Which way was your body pointed at the point of impact? ◯Straight ◯Right ◯Left

Which way was your head pointed at the point of impact? ◯Straight ◯Right ◯Left

_____ _____

Patient signature Date

ATLANTA SPINE CENTER

Patient Name

ACCIDENT DIAGRAM

In the space below, please describe, to the best of your knowledge, what happened during this accident:

DURING THE CRASH:

Position of hands: ○ One on wheel ○ Two on wheel ○ N/A

Did you strike any parts of the vehicle? ○ Yes ○ No

If yes, please describe _____

Did vehicle strike any objects after the crash? ○ Yes ○ No

If yes, please describe _____

Were you aware or surprised of the approaching collision? ○ Aware ○ Surprised

Were you wearing a hat or glasses? ○ Yes ○ No

If yes, were they still on after the crash ○ Yes ○ No

Did you lose consciousness (black out) upon impact? ○ Yes How long? _____ ○ No

Did you experience a flash of light or explosion in your head? ○ Yes ○ No

AFTER THE CRASH

Did you become : ☐ Confused ☐ Disoriented ☐ Light headed ☑ Dizzy
☐ Nauseated ☐ Blurred vision ☐ Ring/Buzz in ears

If you still have any of those symptoms, which ones: _____

Are you currently suffering from any of the following:

☐ Restlessness ☐ Irritable ☐ Difficulty concentrating ☐ Difficulty with memory
☐ Sleeplessness ☐ Forgetful ☐ Reduced tolerance to heat ☐ Reduced tolerance to alcohol

Did the police come to the accident scene? ○ Yes ○ No Is there a report? ○ Yes ○ No

DISABILITY

Do you have a permenant disability rating? _____ Location _____ Date received _____

Rating Percentage _____

_____ _____

Patient signature Date

ATLANTA SPINE CENTER

Patient Name _____

HOSPITAL

Did you go to the hospital? ◯ Yes ◯ No

How did you get to the hospital? _____

Name and city of hospital _____

Name of emergency room doctor _____

What parts of body were x-rayed at the hospital? _____

How long did you stay in the hospital? _____

What did the hospital do for your injuries? ◯ Cervical collar ◯ Ice pack ◯ Other _____

◯ Medications _____ ◯ Follow up instructions _____

PLEASE LIST ALL TREATMENTS FOR CONDITIONS RELATED TO THIS ACCIDENT

1) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

2) Name _____
Address _____
Phone # _____
Specialty _____
Dates of care _____
Tests/Treatments _____
Results _____

HEALTH HABITS: How much per day or week?

Tea, coffee _____ Liqour _____ Tobacco _____ Sugar, candy, ice cream _____

Exercise: 1)Type _____ Frequency _____ 2) Type _____ Frequency _____

3) Type _____ Frequency _____ 4) Type _____ Frequency _____

Sleep: Hours per night _____ Type of mattress _____ Naps _____

Do you sleep on your ◯ Back ◯ Side ◯ Stomach

Please describe your sleep _____

Special diets _____

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD

- ☐ HIV Positive
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Small Pox
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venerial Infection
- ☐ Whooping Cough
- ☐ Cold Sores
- ☐ Allergies
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Hypersensitivity
- ☐ Asthma
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Chicken Pox
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Other _____

_____

Patient Signature _____ Date

ATLANTA
SPINE CENTER

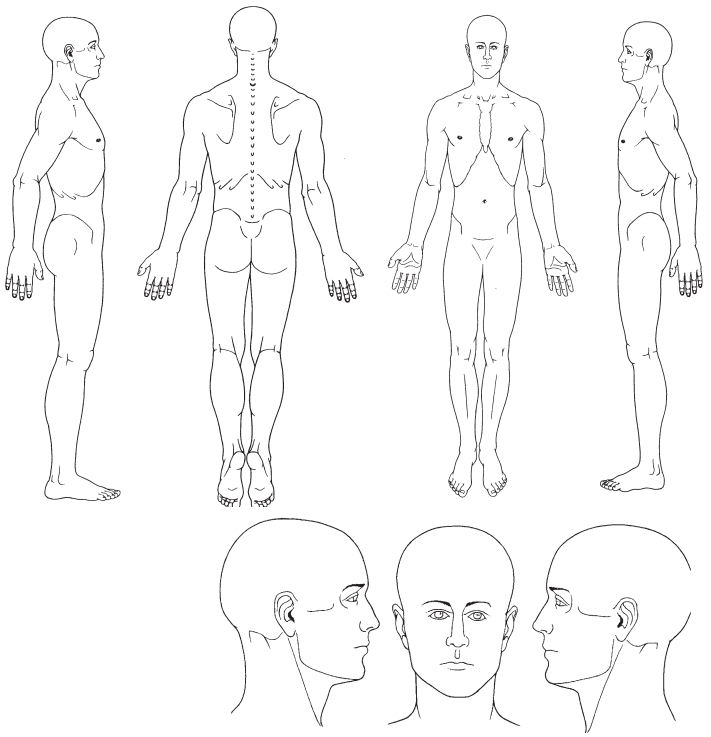
Patient Name

CURRENT COMPLAINTS -

Please list, in detail, all current symptoms / complaints in order of severity

1) _____

Please mark your areas of pain on the figures below



Date when symptom first appeared _____

How often do you experience the symptoms?

◯ Constant 76-100% ◯ Frequent 51-75%

◯ Intermittent 26-50% ◯ Occasional 11-25% ◯ Rare 10%

Describe any recently related accident or fall _____

What makes symptom increase? _____

What gives relief of symptom? _____

Type of pain:

◯ Sharp ◯ Dull ◯ Aching ◯ Burn

◯ Throb ◯ Numb ◯ Other _____

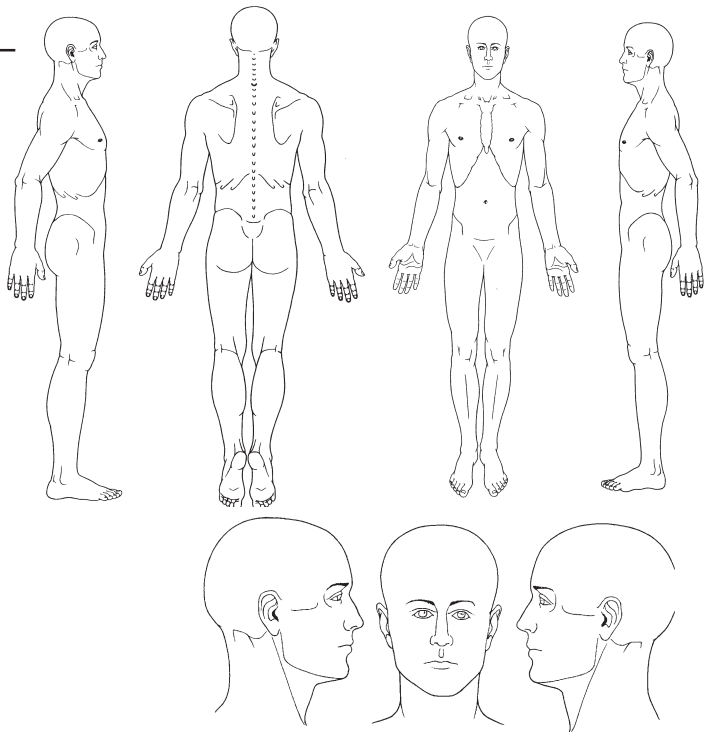
Where does the pain radiate to? _____

How bad is your pain (indicate 0 no pain to 10 unbearable)

0 ——— 5 ——— 10

---

2) _____



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Patient signature

Date

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SPINE CENTER

PAST HEALTH HISTORY

Patient Name _____

Please list all surgeries you have had:

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Please list all previous fractures and dislocations:

What _____ When _____

What _____ When _____

Please list any prior history of current complaints:

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

Please list all prior accidents, associated complaint and treatments:

Date _____ Complaint _____ Treatment _____ Result _____

Date _____ Complaint _____ Treatment _____ Result _____

Please list any medications and/or vitamins you take:

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

OCCUPATIONAL INFORMATION

Job Involves:

○ Sitting ○ Standing How long _____ ○ Desk ○ Counter ○ Other _____

○ Lifting How much weight _____ ○ Bending ○ Stooping ○ Twisting ○ Turning

Type of shoes ○ High heels ○ Boots ○ Arch supports Other ○ _____

How long do you speak on the telephone each day _____ ○ Traditional telephone receiver ○ Headset

Physical activity at work ○ Sedentary ○ Light manual labor ○ Manual labor ○ Heavy manual labor

Do any of your work activities aggravate your present main complaints? Please describe _____

X-RAY CONFIRMATION- FEMALES

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____

Signed Date

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____

Patient Signature Date