BAKKE CHIROPRACTIC CLINIC
PERSONAL INJURY HISTORY FORM (Non-Vehicular)

Name:_____ DOB: _____ Date:_____ Case#:_____

Date of accident:_____ Time of accident:_____ ☐ AM ☐ PM

Location of accident:_____

Describe what happened (be specific):_____

_____

_____

Were you cut or bruised? ☐ Yes ☐ No If yes, describe:_____

Were you knocked unconscious? ☐ Yes ☐ No ❖ Was a police report done? ☐ Yes ☐ No

Did the rescue squad come to the accident? ☐ Yes ☐ No ❖ Were you evaluated by them? ☐ Yes ☐ No

Describe specifically how you felt: **IMMEDIATELY** after the accident_____

_____

later that day_____

the day after_____

List ALL medical doctors, doctors of chiropractic, and physical therapists you have seen since the accident: _____

_____

Are you currently on any work restrictions? ☐ Yes ☐ No If yes, by whom?_____

What are the restrictions?_____

Do you have an attorney? ☐ Yes ☐ No If yes, attorney name:_____ Ph#_____

Before this accident, **were you having symptoms** in the areas of your body now affected? ☐ Yes ☐ No

If yes, what? (be specific)_____

Before this accident, have you **ever** injured or had symptoms in the area of your body now affected? ☐ Yes ☐ No

If yes, what and when? (be specific)_____

Due to physical problems or symptoms, are your daily activities different since the accident? ☐ Yes ☐ No

If yes, what are you unable to do now?_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name:_____ Phone #_____

Address:_____

_____

Name of Insurance Company:_____ Phone #_____

Address:_____

_____

Policy #:_____ Group #:_____ Claim #_____

My signature below verifies that I have read, understood and truthfully answered each question to the best of my ability.

Patient's Signature:_____ Date:_____