

BAKKE CHIROPRACTIC CLINIC
MOVING VEHICLE INJURY HISTORY FORM (Vehicular)

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

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

Were you the: driver front seat passenger rear seat passenger
Driver of vehicle (if not you): _____
Owner of vehicle: _____

Part of your vehicle involved: front rear driver side passenger side rolled

Road conditions: icy snowy rainy wet clear/dry ❖ Did you see the accident coming? Yes No

Approx. speed of your vehicle: _____ mph. Speed of other vehicle: _____ mph. ❖ Did you brace for impact? Yes No

Were your brakes applied? Yes No Unsure ❖ Were you wearing your seat belt/shoulder harness? Yes No

Position of your headrest at the time of the accident, even with? your neck lower half of head upper half of head

Head position at time of impact: turned right turned left looking up looking down looking forward

Body position at time of impact: neutral turned right turned left ❖ Were you cut or bruised? Yes No

Did any part of your body hit anything inside the car? Yes No ❖ Were you knocked unconscious? Yes No

Was a police report done? Yes No ❖ Did the rescue squad come? Yes No ❖ Were you evaluated? Yes No

Describe what happened to you upon impact: _____

Describe how you felt: immediately after the accident _____

later that day _____

the day after _____

Before this accident, **did you have symptoms** in areas of your body now affected? Yes No

If yes, explain: _____

Are your daily activities different since the accident? Yes No If yes, explain: _____

What is painful or difficult to do now _____

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

❖ Do you have an attorney? Yes No

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

What are the restrictions? _____

AUTOMOBILE INSURANCE INFORMATION

Policy Holder Name _____ Phone # _____

Auto Insurance Name _____ Phone # _____

Address _____

Claim # _____ ID# /Group / Policy # _____

Adjuster's Name: _____ Phone # _____

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

Patient's Signature: _____ Date: _____