BAKKE CHIROPRACTIC CLINIC

5220 Pacific Avenue Tacoma, WA 98408 (253) 472-3365

Personal Injury or Automobile Accident History Form

Dec 2012

Welcome to Bakke Chiropractic Clinic Enjoy our state of the art services including DRX disc decompression and professional massage to improve your health.

Patient Information										
Patient First Name	Patient Last Na	me	M.I.	Gender	Age	Date of Birth	(MM/DD/YYYY)			
		IVI.I.			7.90	Date of Birth (MM/DD/YYYY)				
Patient Address		l.	Unit #		City		State	Zip		
					Oity					
Home Phone Cell Phone			Work Phone		Marital Status					
Occupation Francisco Name					│ □S □M □Widov			arated □Divorced		
Occupation Employer Name		Email Address		Social Se		ecurity Number				
Work Address					Lou					
Work Address					City		State	Zip		
Have you seen a chiropractor before? Yes No Referred by Internet Telephone book Insurance list friend/family May we ask your family or friend name?										
Emergency Contac			n who does N	OT live with	n vou)					
First Name		iation (i oloo	Last Name	<u> </u>	i you,	Phone N	Number			
						1 Hone Number				
Your Auto Insurance	ce infor	mation								
Company Name			Agent Name (Purc	chased From)	Agent Phone Nun	Agent Phone Number		Policy Number		
Your Health Insura	nce info	ormation								
Company Name			Agent Phone Num	ber (If available	available) Policy Number		Group Number			
Responsible Party'	s Inforr									
First Name		Last Name		M.I.	Gender □M □F	9		Date of Birth (MM/DD/YYYY)		
Address				Unit #	City		State	Zip		
Auto Insurance Company	Name		Policy Holder's Na	me	Policy Number		Claim Number			
				,						
Attorney Information	on		Name			Phone N	lumber			
Address				Unit #	City		State	Zip		
Where there any w	itness?	□ Yes □ No	If ves. pleas	se list witnes	ss' information					
First Name	11110001	<u> </u>	Last Name	oo not wanto	Phone Number					
Assignment Authorization Agreement Power of Attorney Agreement 1. I hereby assign to this office my rights to receive payments from negligent parties or from insurance companies. Payments should be payable to and mailed to: Bakke Chiropractic Clinic 5220 Pacific Avenue Tacoma, WA 98408 (253) 472 3365 If my policy prohibits assignments, then check should be payable to me and sent to above address. 2. I authorize the office to release any information to any insurance company, adjuster, or attorney that will assist in the payment of my health services claim. 3. I appoint this office as attorney-in-fact to correspond on my behalf with insurance companies, to negotiate any settlement and to cash any settlement draft or check. Attorney's— Counsel, insurance companies, and negligent parties be advised that, no settlement can be effectuated without the agreement of this office or the offices' release of this provision. Said negotiation to be for the payment of health expenses and will not release negligent party from other responsibilities. The office does not intend to "represent" me in any way, this appointment is strictly to prevent negligent parties, attorneys or insurance companies from settling any financial relations with me the patient without fulfilling my financial responsibilities to this office first. 4. I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance. 5. If the office incurs any attorney fees or other collection expenses for the collection of this account because I have not complied with this agreement, I understand that I will be responsible for those fees or expenses in addition to the health care fees. 6. I understand for automobile PIP or third party claims or personal injury claims that Bakke Chiropractic Clinic does not bill or accept payment from HMO or major medical health insurance. 7. A finance charge of 9% per year or .0075% per month will be added on accounts wi										
Patient of Guardian Signature										
Responsible party				Info	ormation Taken By					

	1							
Is illness or injury related to	,	ve other insuran	ice that migh	t If yes	, Please	list oth	er insurar	nce company
□Work □Auto □Other	cover the	njury/illness? 🗆		name				
Please list your reason(s) fo	r the visit or	Date you	Using a sca	ale in whi	ch "0" is	<u>none</u> (no pain oi	r symptom)
your condition(s) in order of	importance	first noticed:					ı(s). Circle	the number
			that best re	flect you	r conditio	n:		
1			0 1	2 3	4 5	5 6	7 8	9 10
2			0 1	2 3	4 5	5 6	7 8	9 10
3			0 1	2 3	4 5	5 6	7 8	9 10
4			0 1	2 3	4 5	5 6	7 8 7 8 7 8 7 8	9 10
5			0 1	2 3	4 5	5 6	7 8	9 10
For reasons or conditions I Developed over time Illing Date and time of your present Present injury (ies) please de	ness □ Injur t injury?	y □ Auto Accide			Other _			
1 resem injury (les) pieuse de	Scribes. Write	и паррепеа:						
What were you doing at the ti Where did your injury take pla How long since your injury? _ For each reason listed above	ece? /e, please cl	eck if it is <u>bett</u>	e <u>r</u> or <u>worse</u>	wit <u>h</u> any		llowin	g:	
HEAT	COLD	REST	ACTIVIT	Y		0	THER	
<u>better</u> <u>worse</u> <u>be</u>	etter worse	better worse	better wor	<u>se</u> bet	ter wors	<u>e</u>		
Reason 1								
Reason 2								
Reason 3								
Reason 4					1 П			
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Reason 5 🗆 🗀 💻								
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Auto Accident Detailed History	
Your position	Your vehicle doingand approximately mph
□ Driver □ Passenger	□ Traveling straight ahead □ Overtaking/Passing
□ 2nd Seat - Right □ 3rd Seat - Right	□ Slowing or Stopped □ Parked
□ 2nd Seat - Middle □ 3rd Seat - Middle	☐ Turning right
□ 2nd Seat - Left □ 3rd Seat - Left	□ Turning left
Vehicle travel direction	Damaged area & Cost to repair? Involved vehicle
□ N □ on Highway	□ Car □ Bus
□ S □ on Street	□ Van □ Truck
□ E □ on Route □ W □ other	□ Pickup □ Other
Where did you go immediately after this accident? □ Drove home □ Drove to work	Were you hospitalized? ☐ Yes ☐ No
☐ Was driven home ☐ Was driven to work	Did you have any x-ray, CT or MRI's taken? ☐ Yes ☐ No It yes, what area?
□ Drove to hospital □ Taken to hospital via	What did the hospital recommend?
was driven to hospital ambulance	what did the hospital recommend:
Were you aware?	Air bag status Seatbelt
☐ Totally unaware that the accident was impending	□ Deployed front □ Lap seatbelt
☐ Aware that the accident was impending	□ Deployed side □ Shoulder-lap seatbelt
☐ Aware that the accident was impending and braced for it	
Position of your HEAD at time of impact?	Was your HEAD thrown?
□ Facing straight ahead □ Tilted forward	□ Backward and then forward □ To the right
□ Facing right □ Facing left	□ forward and then Backward □ To the left
What position was your headrest in at time of impact?	400 400
☐ High (above 1") ☐ High (within 1") ☐ Middle ☐ Low (within 1") ☐ Middle ☐	,
<u>Did you lose consciousness?</u>	Immediately following the accident, did you feel?
□ Yes	□ Dizzy□ Weak□ Blurred vision□ Ring/Buzz in ear
□ No	<u> </u>
In What area did you Immediately feel pain? ☐ Head ☐ L ☐ R Shoulder ☐ L ☐ R Hip	Experience pain on the day FOLLOWING the accident? ☐ Head ☐ L ☐ R Shoulder ☐ L ☐ R Hip
□ Head□ L □ R Shoulder□ L □ R Hip□ Neck□ L □ R Arm□ L □ R Thigh	☐ Head ☐ ☐ R Shoulder ☐ ☐ R Hip☐ Neck ☐ ☐ R Arm ☐ ☐ R Thigh
□ Upper Back □L □ R Elbow □L □ R Knee	□ Upper Back □L □ R Elbow □L □ R Knee
□ Mid Back □L □ R Wrist □L □ R Calf	□ Mid Back □ L □ R Wrist □ L □ R Calf
□ Ribs □L □ R Hand □L □ R Ankle	□ Ribs □ L □ R Hand □ L □ R Ankle
□ Chest □L □ R Finger □L □ R Foot	□ Chest □L □ R Finger □L □ R Foot
□ Abdomen □L □ R Buttock □L □ R Toes	□ Abdomen □L □ R Buttock □L □ R Toes
□ Low back □ Pelvis	□ Low back □ Pelvis
Next day discomfort?	Did your major complaints exist before the accident?
□ Increased □ Decreased □ Same	□ Yes □ No
Have you missed work or household duty due to the accide	ont2 Vos No If you From / / to / /
nave you missed work or nousehold duty due to the accide	
Please draw a diagram of accident below and do you know	the address?
	A Patient Car
X X X I I I K X	B Other Car C Third Car
	O Stop Sign
	North > Yield Sign > Direction of Traffic
	` \

Have you had accident or injuries?	Yes □ No	If yes, plea	ise list type o	f acciden	t and date
1(_) 2	() 3.		()
Have you ever had any broken bone	es before? Yes No	If yes, plea	ise indicate lo	ocation ar	nd date
1 ((_) 2	() 3.		()
1 (_) 2	() 3.		()
Have you had any childhood, adult il					
1 (((_) 2	() 3.		(
4 (_) 5	() 6.		()
Have you been diagnosed as having	HIV exposure? ☐ Yes	s □ No If yes, indica	te when diag	nosed?	()
Family History		NAME OF THE RESERVE	4 (1 1 1 1	1.0	
What is the status Father's health?	monte all /E.Eathar M.	What is the status M	lotner's nealt	n'?	
If they have (had) a disease, please	•	-	.4\	Montali	Unaca (E/M)
□ Autoimmune disorder (F/M)					
□ Arthritis (F/M) Present History	□ Diabetes (F/M)	□ Niuriey disease (F	/IVI) L	Seizure	(F/IVI)
Are you currently taking any prescrip	ation or over-the-count	or-modicino2 □ Voc □	No If yes	nlease lis	at them and
Are you currently taking any prescrip	mon or over-the-count			ng taken	
1.	()	2.			
1 3	()	4.			_ (
Do you have any medication or over	-the-counter-medication	on allergies? □Yes. □N	lo If ves. ple	ease list t	type of allergy
1		_)
3.		4.			
Do you have any other allergies?				ease list t	type of allergy
1		2.	•		• • • • • • • • • • • • • • • • • • • •
3.		1			
		甘.			
	en treated for this pas	+ t years? □ Yes □ No	If yes, ho	w did yo	u respond?
Are there injuries which you have be	en treated for this pas	t years? □ Yes □ No	If yes, ho	w did you	u respond?
		t years? □ Yes □ No			u respond?
	Doctor name	t years? □ Yes □ No	If yes, ho		u respond?
Are there injuries which you have be	Doctor name	t years? Yes No			u respond?
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Are there injuries which you have be	loctor Doctor name				
Please list your primary medical of Clinic Address	Doctor name Unit #		Clinic name	State	Zip
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