

CONFIDENTIAL CASE HISTORY
PERSONAL INJURY
VAN ROON CHIROPRACTIC
391 EAST CENTRAL ST, FRANKLIN, MA. 02038



Name _____ Social Security # _____
 Address _____ City _____ State _____ Zip _____
 Home Telephone _____ Work Telephone _____ Email _____
 Emergency Contact Name _____ Relationship _____ Tel. _____
 Age _____ Birthdate _____ # Children _____ Height _____ Weight _____
 Occupation _____ Employer _____
 Are you pregnant Yes No Date of onset of last menstrual cycle _____

DESCRIPTION OF THE ACCIDENT

Where did the accident happen? City/Town _____
 Date of Accident: _____ Time: _____ AM PM
 Driver of car: _____ Where were you seated? _____
 Who owns the car? _____ Year and model of car: _____
 Damage done to the car you were in? Scrapes and Dents Structural Damage Totaled
 Your car: Hit another car Was hit in the: Right Left Rear Front Side
 How fast would you estimate you were going? Stopped 1 - 15 MPH 16 - 45 MPH Over 45 MPH
 How fast was the other car travelling? Stopped 1 - 15 MPH 16 - 45 MPH Over 45 MPH
 Describe in your own words what happened to you upon impact: _____

Did you hit your head? Yes No Were you knocked unconscious? Yes No
 Did you get bleeding cuts or bruises? Yes No
 If yes, describe _____
 Please describe how you felt. _____
 Immediately after the accident: _____

DOCTOR/HOSPITAL SEEN

Doctor/Hospital Seen: _____ Date of first visit: _____
 How did you get there? Someone else drove me Drove own car Ambulance Police
 Were X-rays taken? Yes No
 What treatment was given to you? _____
 What benefits did you receive from the treatment? _____
 Date of last treatment? _____