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FIVE POINTS CHIROPRACTIC WELLNESS CENTER

Pediatric Auto Accident History

Today's Date: June 29, 2012

Patient's Name _____ Sex: ☐ F ☐ M Date of Birth _____

ABOUT THE ACCIDENT

Date of Accident _____ Time of day _____ a.m. / p.m.

Location of the Accident _____

Direction of Impact ☐ Front- end ☐ Rear-end ☐ Left side ☐ Right side ☐ Rollover

Did collision involve ☐ Another vehicle ☐ Other object _____

Non- collision injury ☐ Near-miss ☐ Spin out ☐ Sudden stop

Child's position in vehicle ☐ Front right ☐ Front left ☐ Front center ☐ Rear right ☐ Rear left ☐ Rear center

Care seat type ☐ Regular seat ☐ Infant seat ☐ Boost seat ☐ Facing front ☐ Facing rear

Was child wearing seat belt? ☐ No ☐ Yes ☐ Lap/ Sash ☐ Lap only ☐ Harness

At time of accident child was ☐ Facing front ☐ Facing right ☐ Facing left ☐ Asleep ☐ Other

Were head rests fitted? ☐ No ☐ Yes

Did the air bags inflate? ☐ No ☐ Yes

Was child struck by airbag? ☐ No ☐ Yes

Did the child strike any object within the vehicle? ☐ No ☐ Yes

Speed of your vehicle _____ mph Speed of other vehicle _____ mph

Make and model of your vehicle _____

Make and model of other vehicle _____

Was a police report filed? ☐ No ☐ Yes

Describe the accident _____

_____

Signed by _____ Date _____

Relationship to child _____

ABOUT THE CHILD'S INJURIES

Child has no apparent symptoms ☐

Please describe any apparent symptoms _____

Do you have other concerns about your child's condition? _____

Has the child previously been examined or treated since the accident? ☐ No ☐ Yes

Name of hospital or treating doctor _____ Date _____

Were x-rays taken? ☐ No ☐ Yes

Described any treatment already received _____

Is the child's condition ☐ Getting better ☐ Getting worse ☐ Constant ☐ Intermittent

When did symptoms start? ☐ Immediately ☐ Later that day ☐ Next day ☐ Days later

DOES THE CHILD COMPLAIN OF ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Pain or soreness?	☐	☐	Irritability or fatigue?	☐	☐
Joint aches or stiffness?	☐	☐	Chest pain?	☐	☐
Limited or painful motion?	☐	☐	Abdominal pain?	☐	☐
Headaches?	☐	☐	Nausea?	☐	☐
Neck pain?	☐	☐	Back pain or stiffness?	☐	☐
Dizziness?	☐	☐	Leg pain?	☐	☐
Difficulty sleeping?	☐	☐	Arm pain?	☐	☐

ABOUT YOUR MOTOR VEHICLE INSURANCE COMPANY

Name of your auto insurance company _____

Claims Agent _____ Agent's phone number _____

Policy number _____ Claim number _____