PEDIATRIC AUTO ACCIDENT HISTORY

Today's Date ________________

Child's Name ________________________________ Sex: M F Date of Birth ____________ Age _____

ABOUT THE ACCIDENT

Date of Accident ___________________ Time of day _______ a.m. / p.m.

Location of 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

Car seat type ☐ Regular seat ☐ Infant seat ☐ Booster seat ☐ Facing front ☐ 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 the other vehicle ____

Was a police report filed? ☐ No ☐ Yes

Describe the accident ____

____

Signed by ____ Date ________________________

Relationship to child ___________________________________

© 2001 by Peter Fysh, D.C. All rights reserved.

PEDIATRIC AUTO ACCIDENT HISTORY

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

Describe 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:

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

ABOUT YOUR MOTOR VEHICLE INSURANCE COMPANY

Name of your auto insurance company ______________________________

Claims Agent ______________________ Agent's phone number ______________

Policy number ______________________ Claim Number ______________

© 2001 by Peter Fysh, D.C. All rights reserved.