Pediatric Auto Accident History

Today's Date _____

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

Parent/Guardian Names_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer Name (financially responsible party): _____

Employer Address (financially responsible party): _____

Insured's Social Security Number: _____ Family Physician: _____ Phone: _____

Who may we thank for referring you to our office? _____

E-Mail Address (for appointment reminders): _____

How will you be paying today? □ Cash □ Check □ Credit Card (Visa, MC, AMEX, Discover)

Health Information:

What is your reason for consulting our office: _____

Has any previous doctor created a health development program for your child? □ Yes □ No

Did you/your child follow all the doctor's recommendations? □ Yes □ No

How long was your child able to stay on the health development plan? _____

What were your child's results? _____

Has your child had previous chiropractic care? □ Yes □ No This year? □ Yes □ No

What other wellness professionals are a part of your family's healthcare team?

□ Massage Therapist □ Nutritional Counselor □ Personal Trainer □ Other _____

How many medical doctor office visits did your child have last year? _____ Your family?_____

List any surgeries your child has had (include dates): _____

Please list medications your child is taking, including vitamins and supplements: _____

_____

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 □ Facing rear

Was the child wearing seat belts □ 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 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 of treating doctor _____

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 of stiffness? □ No □ Yes

Limited or painful motion? □ No □ Yes

Headaches? □ No □ Yes

Neck pain □ No □ Yes

Dizziness	□ No	□ Yes
Difficult 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 _____ Agents phone number _____

Policy number _____ Claim number _____

Lifestyle Information:

Does your child get 30 minutes of continuous physical activity each day? □ Yes □ No

What type of activity? _____

Is the child's diet healthy? □ Yes □ No How would you describe the diet? _____

How much water does your child drink each day? _____

Stress History:

Please indicate whether your child has experienced stress in any of the following areas. Your answers will help us determine factors that may have contributed to your child's health concerns.

Repeated/prolonged Antibiotic Use	□ Yes □ No	Head Trauma	□ Yes □ No
Car Accident	□ Yes □ No	Prescription Medications	□ Yes □ No
Severe/Recurrent Childhood Illness	□ Yes □ No	Surgery	□ Yes □ No
Fall/Jump from a height < 3 feet	□ Yes □ No	Vaccination	□ Yes □ No
Fall/Jump from a height > 3 feet	□ Yes □ No	Youth Sports	□ Yes □ No
Other Traumas (physical or emotional)	□ Yes □ No		

If yes, please list: _____

On a scale of 1-10, please describe your child's stress level: (1=none, 10=extreme) _____

Which best describes your reason for consulting our office?

- □ I have a specific concern and require only help with this concern
- □ I want to ensure that my child's health concerns do not become an ongoing problem that will impact his/her future health
- □ I want my child to be healthier five years from now than he/she is today

The statements made on this form are accurate to the best of my recollection and I grant permission for this office to examine my child and evaluate their health.

_____ _____

Parent/Guardian Signature Date