# 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 _____

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**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 _____