Rushmore Family
CHIROPRACTIC

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Today's date: _____

Child's name:_____ Sex: M F Date of birth:_____

Parent's name: _____

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 the collision involve : _____Another vehicle or _____ Other object If so, what:_____

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 your child wearing a seat belt: _____ Yes ____ No ____ Lap/Sash _____ Lap only _____ Harness

At time of accident child was: ____ Facing front _____ Facing right _____ Facing left _____ Asleep _____ Other

Did airbags inflate? _____ Yes _____ No Was your child struck by an airbag? _____ Yes _____ No

Did your child strike any object within the vehicle? _____ Yes _____ No

Speed of your vehicle: _____ Speed of the other vehicle: _____

Make and model of your vehicle: _____

Make and model of the other vehicle: _____

Was a police report filed? _____ Yes _____ No

Describe the accident: _____

_____

_____

_____

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ABOUT THE CHILD'S INJURIES

☐ Child has no apparent symptoms.

Please describe any apparent symptoms: _____

_____

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

Name of hospital or treating doctor: _____ Date of treatment: _____

Were x-rays taken? ____ Yes ____ No

Since the accident, are your child's symptoms: _____ Getting better _____ Getting worse _____ Constant _____ Intermittent

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

DOES YOUR CHILD COMPLAIN OF ANY OF THE FOLLOWING:

_____Pain or soreness _____Joint aches or stiffness _____Limited or painful motion _____Headaches

_____Neck pain _____Dizziness _____Difficulty sleeping _____ Irritability or fatigue

_____Chest pain _____ Abdominal pain _____Nausea _____ Back pain

_____ Leg pain _____ Arm pain

MOTOR VEHICLE INSURANCE COMPANY

Name of your auto insurance company: _____

Claims Agent: _____ Agent's phone number: _____

Policy number: _____ Claim Number: _____

Signature _____ Date: _____

Relationship to child: _____