



Dr. Heather Whittle • Chiropractor

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This information will be strictly confidential. Please print neatly, fill out completely, and be as accurate as possible.

Patient Information

| | | | |
|--|---------------|---------------|---|
| Print Full Name: | | Today's date: | |
| Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth | / | / |
| | | Age: | |

Insurance Information

| | | | |
|--------------------------------------|----------------|---------------|--|
| Name of your auto insurance company: | | Claims agent: | |
| Agent's telephone: | Policy number: | Claim number: | |

Accident Information

| | | |
|---|--|---|
| Date of accident: | Time of day: | <input type="checkbox"/> AM <input type="checkbox"/> PM |
| Location of accident: | | |
| Direction of impact: | <input type="checkbox"/> Front-end <input type="checkbox"/> Rear-end <input type="checkbox"/> Left side <input type="checkbox"/> Right side <input type="checkbox"/> Rollover | |
| Did collision involve: | <input type="checkbox"/> Another vehicle <input type="checkbox"/> Other object: | |
| Non-collision injury: | <input type="checkbox"/> Near-miss <input type="checkbox"/> Spin out <input type="checkbox"/> Sudden stop | |
| Child's position in vehicle: | <input type="checkbox"/> Front-right <input type="checkbox"/> Front left <input type="checkbox"/> Front center <input type="checkbox"/> Rear right <input type="checkbox"/> Rear left <input type="checkbox"/> Rear center | |
| Car seat type: | <input type="checkbox"/> Regular seat <input type="checkbox"/> Infant seat <input type="checkbox"/> Booster seat <input type="checkbox"/> Facing front <input type="checkbox"/> Rear | |
| Was child wearing a seat belt? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lap/Sash <input type="checkbox"/> Lap only <input type="checkbox"/> Harness | |
| At time of accident, child was: | <input type="checkbox"/> Facing front <input type="checkbox"/> Facing right <input type="checkbox"/> Facing left <input type="checkbox"/> Asleep <input type="checkbox"/> Other: | |
| Were head rests fitted? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Did the airbags inflate? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Was child struck by airbag? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Did the child strike any object within the vehicle? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Describe the accident: | | |

Please continue on the other side.

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?

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

Name of hospital or treating doctor:

Date:

Were x-rays taken? Yes No

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? Yes No Describe:

Joint aches or stiffness? Yes No Describe:

Limited or painful motion? Yes No Describe:

Headaches? Yes No Describe:

Neck pain? Yes No Describe:

Dizziness? Yes No Describe:

Difficulty sleeping? Yes No Describe:

Irritability or fatigue? Yes No Describe:

Chest pain? Yes No Describe:

Abdominal pain? Yes No Describe:

Nausea? Yes No Describe:

Back pain or stiffness? Yes No Describe:

Leg pain? Yes No Describe:

Arm pain? Yes No Describe:

Parent Acknowledgement

Signed by _____

Relationship to Child _____

Date _____

Pediatric Vehicle Accident Questionnaire 0705