D: Child/Parent/Guardian questionnaire

For completion by the parent/guardian in consultation with the injured child as appropriate.

Name of child

Date of accident:
[month, day, year]

The information you provide in this questionnaire will be used, along with medical reports, to assess your child's claim for damages. Please be as accurate as possible. It may be helpful for you to discuss your child's condition with them prior to completing the form. If the form does not provide you with sufficient space, please feel free to attach additional pages or write on the back of the form.

1. Circumstances

Describe exactly happened in the accident. If the accident was a motor vehicle accident, the description should address the following: where was your child situated? Were they wearing a seatbelt? What was the estimated speed at the time of impact? Was it a two car accident? Etc.

2. Injuries

Describe in detail the injuries your child sustained as a result of this accident.

3. School missed

Did your child miss school as a result of the accident? If so, how many days were missed?

4. Degree of pain/suffering

Please answer the following questions:

a. In which parts of their body did your child experience pain?

b. How frequently did your child experience pain?

c. When your child experienced pain, how long did it last?

d. Was your child's pain worse at certain times of the day?

e. Did the pain interfere with your child's sleep?

f. Did the pain interfere with the child's ability to engage in physical education, sports or other types of activities? Please describe (e.g. how was your child limited or restricted? Which activities were restricted? What activities could your child not participate in? etc.)

g. By what date had your child returned to all their usual sports and activities?

5. Treatment

a. If your child suffered a soft tissue injury, please indicate what treatment your child underwent by ticking the relevant box.

- ☐ medications
- ☐ heat/ice
- ☐ rest/limiting activities
- ☐ home exercises
- ☐ physiotherapy
- ☐ chiropractic
- ☐ massage therapy
- ☐ acupuncture
- ☐ Back Institute
- ☐ Other

Provide the names of your child's treatment providers and indicate the number of appointments attended with each one:

b. If your child suffered another type of injury, describe what treatment was provided and who provided it.

6. By what date was your child symptom free?

7. Is there anything further you would like to add? (E.g. how did the injury affect your child's life?)

Date

Signature **Signature**

Print name **Print name**