

# CAR ACCIDENT ADDENDUM

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of accident \_\_\_\_\_ Time of accident \_\_\_\_\_

You were the  Driver  Front seat passenger  Back seat passenger (left)  Back seat passenger (right)

**YOUR** vehicle model/make \_\_\_\_\_ **OTHER** vehicle model/make \_\_\_\_\_

Type of accident:  Head-on  Other vehicle rear ended me  I rear ended other vehicle  Broadside  Other

Explain what happened \_\_\_\_\_

How fast were you going? \_\_\_\_\_mph How fast was the other vehicle going? \_\_\_\_\_mph

Top of headrest was even with  base of my skull  top of my head  middle of my neck

Visibility during accident  Good  Fair  Poor Road conditions during accident  Good  Fair  Poor

Did you see this coming and brace for impact?  Yes  No Was your shoulder harness on?  Yes  No

At impact, your head was  straight forward  turned left  turned right  looking up  looking down

At impact, your body was  sitting straight  turned left  turned right  bent forward

Your state after impact?  unconscious  dazed, needed assistance  shaken, but could function

Did you get out unaided?  Yes  No If NO, explain \_\_\_\_\_

When did your symptoms begin?  Right away  Later that day  The next day  Other \_\_\_\_\_

If you haven't already, list your symptoms: \_\_\_\_\_

Have you undergone any evaluation or treatment so far for these symptoms?  Yes  No If YES, explain below

\_\_\_\_\_

Did you have pre-existing problems in the same areas as your complaints?  Yes  No If YES, explain below

\_\_\_\_\_

Have you ever received treatment for pre-existing problems to these areas?  Yes  No

If "Yes", explain in detail below and note how they are different, if at all, from your current complaints

\_\_\_\_\_

When was the last treatment? \_\_\_\_\_ Were you fully recovered?  Yes  No

Past surgical history: \_\_\_\_\_