

CAR ACCIDENT ADDENDUM

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 how the accident 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 brace yourself 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 _____

List your symptoms _____

Did you have any physical complaints right before this accident? 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

Write any comments or any other information you feel will be helpful regarding this accident and/or your symptoms