CAR ACCIDENT ADDENDUM

Name _____ Height _____ Weight _____ Today's Date _____

Address _____ Phone _____

Date of accident _____ Time of accident _____

YOUR vehicle model/make_____ **OTHER** vehicle model/make_____

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

Type of crash ☐ Head-on ☐ I was rear ended ☐ 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 ☐ Poor Road conditions during accident ☐ Good ☐ Poor

Did you see this coming? ☐ 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 _____

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 and/or treatment 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 any problems to these same areas? ☐ Yes ☐ No If YES, explain in detail

noting 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 _____