STRANGULATION ADDENDUM

Patient Identification

Did the suspect apply any pressure to your neck with any part of his/her body or an object, at any point during the assault? ☐ **NO**, skip this page ☐ **YES**, fill this page out

What did the suspect strangle you with (e.g., hands, chokehold, cord)?

Were you able to breathe? If yes, were you able to speak? What did you say?

Did the suspect say anything while strangling you?

Did the suspect do anything else (e.g., hit, kick, headbutt) while strangling you?

Were you able to do anything to physically stop the strangulation? If yes, what?

What did you think during the strangulation?

NECK SYMPTOMS EXPERIENCED **DURING** THE STRANGULATION

Difficulty breathing?	☐ No	☐ Yes
Unable to breathe?	☐ No	☐ Yes
Neck pain?	☐ No	☐ Yes
Other?	☐ No	☐ Yes

BRAIN HYPOXIA SYMPTOMS EXPERIENCED **DURING** THE STRANGULATION

Vision changes (e.g., tunnel, spot, darkness)?	☐ No	☐ Yes
Hearing loss or changes (e.g., ringing, vibration)?	☐ No	☐ Yes
Dizziness?	☐ No	☐ Yes
Feeling faint?	☐ No	☐ Yes
Lightheaded?	☐ No	☐ Yes
Disoriented?	☐ No	☐ Yes
Headache?	☐ No	☐ Yes
Other?	☐ No	☐ Yes

BRAIN ANOXIA SYMPTOMS EXPERIENCED **DURING** THE STRANGULATION

Did you lose consciousness?	☐ No	☐ Yes
From the start of the hypoxic symptoms to the end of the strangulation, is there a gap in your memory?	☐ No	☐ Yes
Did your position change during the strangulation (e.g., standing to laying)?	☐ No	☐ Yes
If yes, do you remember changing positions?	☐ No	☐ Yes
Do you remember the suspect letting go?	☐ No	☐ Yes
After the strangulation, did you notice you had urinated or defecated?	☐ No	☐ Yes
If yes, do you remember urinating or defecating?	☐ No	☐ Yes

UPPER BODY SYMPTOMS EXPERIENCED **AFTER** THE STRANGULATION (indicate if present at time of exam)

Neck pain?	☐ No	☐ Yes	☐ At time of exam
Difficulty breathing?	☐ No	☐ Yes	☐ At time of exam
Pain with breathing?	☐ No	☐ Yes	☐ At time of exam
Coughing?	☐ No	☐ Yes	☐ At time of exam
With blood?	☐ No	☐ Yes	☐ At time of exam
Without blood?	☐ No	☐ Yes	☐ At time of exam
Raspy/hoarse voice/voice changes?	☐ No	☐ Yes	☐ At time of exam
Pain with speaking?	☐ No	☐ Yes	☐ At time of exam
Trouble swallowing?	☐ No	☐ Yes	☐ At time of exam
Painful swallowing?	☐ No	☐ Yes	☐ At time of exam
Sore throat?	☐ No	☐ Yes	☐ At time of exam
Nausea?	☐ No	☐ Yes	☐ At time of exam
Dry heaving/vomiting?	☐ No	☐ Yes	☐ At time of exam
Other?	☐ No	☐ Yes	☐ At time of exam

NEUROLOGICAL (NEURO) SYMPTOMS EXPERIENCED **AFTER** THE STRANGULATION (indicate if present at time of exam)

Problems with memory, recall, concentration? If yes, give examples.	☐ No	☐ Yes	☐ At time of exam
Examples: _____			
Vision changes or problems?	☐ No	☐ Yes	☐ At time of exam
Photosensitivity?	☐ No	☐ Yes	☐ At time of exam
Hearing changes or problems?	☐ No	☐ Yes	☐ At time of exam
Dizziness or dizzy spells?	☐ No	☐ Yes	☐ At time of exam
Feeling faint?	☐ No	☐ Yes	☐ At time of exam
Lightheaded?	☐ No	☐ Yes	☐ At time of exam
Confusion?	☐ No	☐ Yes	☐ At time of exam
Disoriented?	☐ No	☐ Yes	☐ At time of exam
Headache?	☐ No	☐ Yes	☐ At time of exam
Numbness or tingling?	☐ No	☐ Yes	☐ At time of exam
Fatigue or sleepiness?	☐ No	☐ Yes	☐ At time of exam
Other?	☐ No	☐ Yes	☐ At time of exam

TOTAL # OF INJURIES INFLICTED BY THE SUSPECT

Total # of strangulations?

Total # of strangulations with **LOC** or memory gap?

SUPPLEMENTAL HISTORY SECTION

_____

_____

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