60 SYMPTOMS FROM ACCIDENT

10 Did you get bleeding cuts or bruises? ☐ No

20 If yes, what bleeding cuts did you get from this accident? _____

If yes, what bruises did you get from this accident? _____

30 Please describe how you felt. *PLEASE BE SPECIFIC.*

Immediately after the accident: _____

40 Later that ☐ Day ☐ Night: _____

50 The next day(s): _____

60 Check symptoms apparent **since** the accident:

☐ Headache	☐ Dizziness	☐ Loss of memory	☐ Sleeping problems	☐ Constipation
☐ Neck pain/stiffness	☐ Fainting	☐ Fatigue	☐ Numbness in toes	☐ Chest pain
☐ Midback pain	☐ Ringing/buzzing ears	☐ Tension	☐ Numbness in fingers	☐ Nervousness
☐ Low back pain	☐ Loss of balance	☐ Shortness of breath	☐ Cold hands	☐ Cold sweats
☐ Eyes sensitive to light	☐ Loss of smell	☐ Irritability	☐ Cold feet	☐ Anxious
☐ Pain behind eyes	☐ Loss of taste	☐ Depression	☐ Diarrhea	☐ Other_____

70 WORK STATUS HISTORY

10 Occupation: _____ Employer: _____

20 **Have you** missed time from work? ☐ Yes ☐ No

30-40 If Yes: Full time off work _____

50 If Yes: Part-time off work _____

60 ☐ Been unable to work since accident.

80 FIRST DOCTOR/HOSPITAL/CLINIC SEEN

10 Did you go to seek medical help immediately/soon after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ Someone else drove me ☐ Drove own car ☐ Ambulance ☐ Police

DOCTOR 1/HOSPITAL/CLINIC SEEN: _____ Date of first visit: _____

20 Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

30 Were you given treatment? ☐ No

40 If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

50 Date of last treatment: _____

90 SECOND DOCTOR/CLINIC SEEN

10 DOCTOR 2/CLINIC SEEN: _____ Date of first visit: _____

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

20 Were you given treatment? ☐ No

30 If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

40 Date of last treatment: _____

100 THIRD DOCTOR CLINIC SEEN

10 DOCTOR 3/CLINIC SEEN: _____ Date of first visit: _____

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

20 Were you given treatment? ☐ No

30 If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

40 Date of last treatment: _____