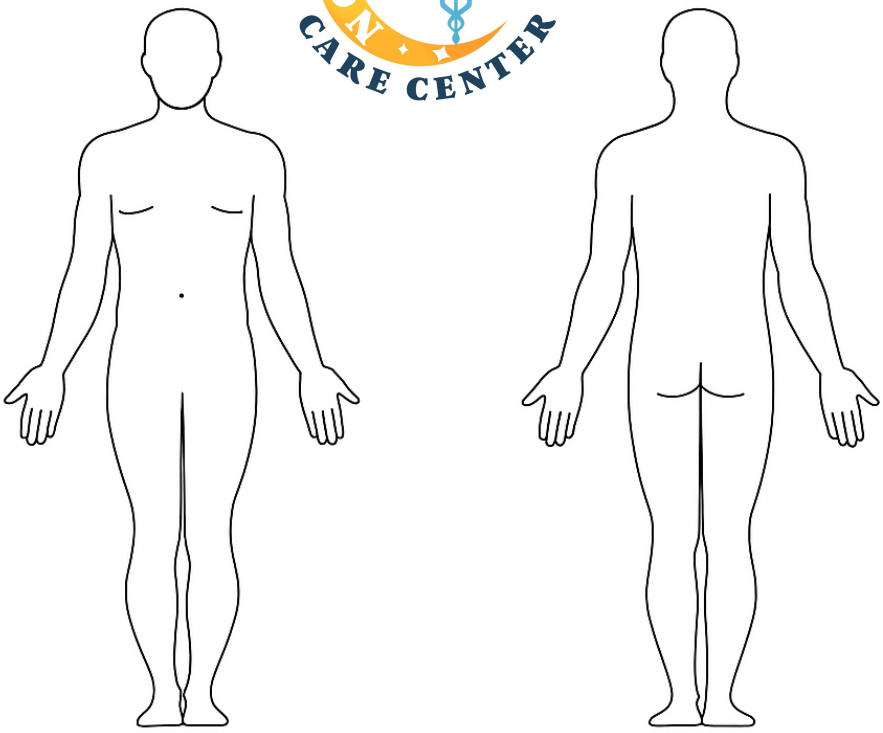

On the above pictures, please circle all area that have painful since the accident.

In motion/moving	Stopped/ Stationary
DRIVER	PASSENGER
Restrained	Front Back

INJURY QUESTIONNAIRE

Did you HIT:

HEAD Yes ☐ No ☐

HEADACHES Yes ☐ No ☐

ARM Left ☐ Right ☐

SHOULDER Left ☐ Right ☐

LEG Left ☐ Right ☐

KNEE Left ☐ Right ☐

Loss of Consciousness: Yes ☐ No ☐

Were any of these current issues present prior to this accident?

Yes ☐ No ☐

If yes, what was pre-existing and is it worse since this accident?

_____

_____

Patient Initials: _____ Date: _____