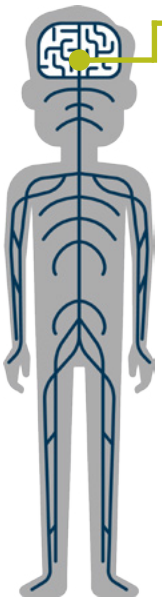
1.0 Head and Central Nervous System.

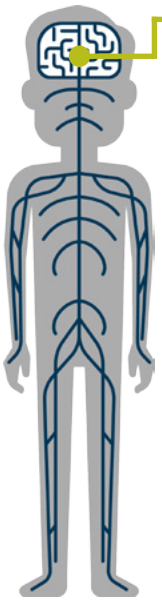


1.1 PHYSICAL SYMPTOMS

Please tick all of the symptoms you have experienced since the accident.

Tick here:

- ☐ Concussion?
- ☐ Dizziness?
  - How long for (days, weeks, months)?
- ☐ Headaches?
  - How frequently (per day, per week)?
  - How long for (minutes, hours)?
- ☐ Loss of function or paralysis to any part of body?
- ☐ Development of epilepsy?



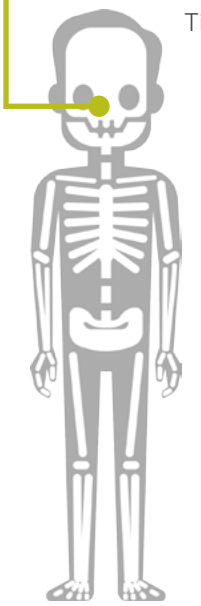
1.2 BEHAVIOURAL SYMPTOMS

Please select true or false to the below statements.

	TRUE	FALSE
I have limited or no memory of the accident	○	○
I have noticed changes in my personality	○	○
I have had feelings of sadness or depression	○	○
I sometime feel that I cannot concentrate	○	○
I sometimes feel that I cannot control my mood	○	○
I find that I forget things more often	○	○

2.0 Facial Injuries.

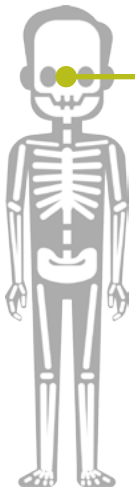
Please tick all of the symptoms you have experienced since the accident.



Tick here:

- [ ] Facial fracture (including any part of the head such as the skull, nose, eye socket(s), cheekbone(s), jaw(s)):
  - [ ] Did it require surgery? If so, number of operations? _____
  - How long was your rehabilitation treatment? _____
  - What type of treatment was provided? _____
  - [ ] Have you developed arthritis in that area as a result?
  - [ ] Do you still suffer from pain in the area?
    - If so how frequently (daily, weekly, monthly)? _____
  - [ ] Has it impacted on your functionality (eating, reduced/difficult movement)?
  - [ ] Have you noticed changes to the sensitivity of the skin?
  - [ ] Do you feel pins and needles in the fractured area?
- [ ] Injury to your teeth or gums?
  - [ ] Did you lose any teeth? If so, how many? _____
  - [ ] Did you suffer any damage to your gums?
  - [ ] Have you developed a gum infection as a result of any damage?
- [ ] Facial scarring?

3.0 Injuries Affecting the Senses.

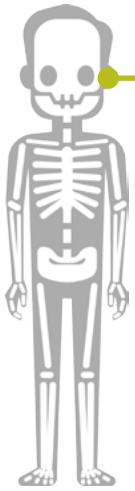


3.1 SIGHT

Please tick all of the symptoms you have experienced since the accident.

Tick here:

- [ ] Lost vision in one or both eyes?
- [ ] Blurry vision in one or both eyes?
- [ ] Double vision in one or both eyes?
- [ ] Constant pain in one or both eyes



3.2 HEARING

Please tick all of the symptoms you have experienced since the accident.

Tick here:

- [ ] Tinnitus (constant ringing sound)?
- [ ] Vertigo (extended feeling of dizziness)?
- [ ] Reduction in hearing to one or both ears?
- [ ] Changes in your ability to speak?
- [ ] Issues with balance?

3.2 TASTE AND SMELL

Please tick all of the symptoms you have experienced since the accident.

Tick here:

- [ ] Reduction in smell?
- [ ] Reduction in taste?

4.0 Injuries to Internal Organs.

4.1 CHEST

Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Collapsed lung?
  - ☐ Did you have a intercostal catheter inserted?
- ☐ Heart or lung complications?
- ☐ Did you break any ribs?
  - If so, how many? _____
  - ☐ Any complications from these fractures?
  - ☐ Ongoing pain from fractures? For how long (days, weeks, months)? _____
  - ☐ Has this affected your ability to perform daily functions (i.e. work)?
- ☐ Lacerations (cuts) on your chest, abdomen or side?
- ☐ Did you inhale any toxic fumes?
- ☐ Shortness of breath?
  - ☐ Has this affected your ability to perform daily functions (i.e. work)?
- ☐ Development of need to use an inhaler or increase use of an inhaler?
- ☐ Development of Asthma?
- ☐ Significant bruising to your chest, abdomen or side?

4.2 DIGESTIVE AND BOWEL SYSTEM

Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Have you had to change any part of your diet?
- ☐ Difficulty swallowing?
- ☐ Requirement of an ileostomy or colostomy bag (even for a short period of time)?
  - If so, for how long (days, weeks, months, permanently)? _____
- ☐ Consistently irregular bowel movements

4.3 LIVER, GALLBLADDER OR BILIARY DUCT

Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Intermittent nausea or vomiting?
- ☐ Jaundice?

4.4 BLADDER

Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Loss of bladder control?
- ☐ Incontinence?
- ☐ Pain urinating?
- ☐ Development of a bladder infection?

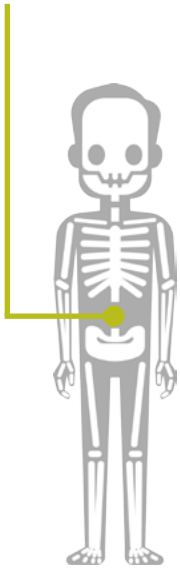
4.5 HERNIA

Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Development of a hernia?
- ☐ Do you suffer ongoing pain?
- ☐ Has it affected your ability to perform daily functions (i.e. work)?

5.0 Spinal Injuries.



5.1 DIAGNOSED INJURIES

Please tick if you have been diagnosed with any of the below injuries.

Tick here:

- ☐ Broken vertebrae (bone) or disc (joint between the vertebrae)?
  - How many vertebrae or discs were broken? _____
  - ☐ Do you have any ongoing pain?
- ☐ Prolapsed or slipped disc?
- ☐ Whiplash?
  - ☐ Any ongoing pain?
  - How long was your recovery (weeks, months, years)? _____

5.1 RELATED SYMPTOMS

Please tick if you have noticed any of the below symptoms.

Tick here:

- ☐ Reduced reflexes?
- ☐ Loss of muscle strength?
- ☐ Loss of feeling in back?
- ☐ Constant or repetitive pain in your back?

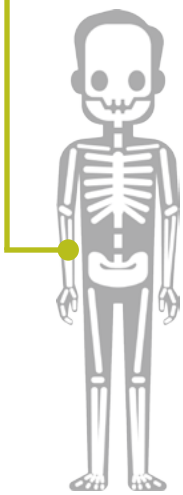
6.0 Shoulder Injuries.

Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Broken shoulder, collarbone or shoulder blade?
  - ☐ Did you require surgery or treatment?
    - If so, what treatment? _____
  - ☐ Is the injury to your dominant side?
  - ☐ Have you developed arthritis as a result?
  - ☐ Have you increased your risk of arthritis as a result?
  - ☐ Ongoing pain?
- ☐ Dislocation of your shoulder, collarbone, shoulder blade or AC joint (point where your collarbone connects to your shoulder)?
- ☐ Reduced shoulder or arm movement?
- ☐ Paralysis or partial paralysis of shoulder or arm?
- ☐ Stretched or torn tendons?
- ☐ Stretched or torn ligaments?
- ☐ Significant bruising?

7.0 Arm Injuries.

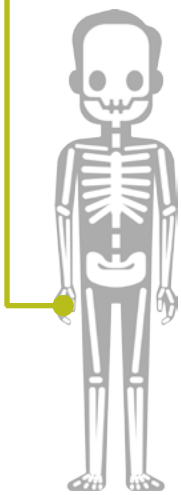


Please tick all of the symptoms your have experienced after the accident.

Tick here:

- Arm fracture (including crush injuries) to your elbow, wrist, humerus (upper arm), radius (lower arm) or ulna (lower arm)?
  - Did you require surgery or treatment?
    - If so, what treatment?
  - Is the injury to your dominant side?
  - Have you developed arthritis as a result?
  - Have you increased your risk of arthritis as a result?
  - Ongoing pain?
- Tennis elbow (pain in outside area of elbow)?
- Golf elbow (pain in inside area of elbow)?
- Lacerations (cuts) to your arm(s)?
- Reduced wrist or elbow movement?
- Stretched or torn tendons?
- Stretched or torn ligaments?
- Reduced ability to grip objects?
- Reduced ability to push objects?
- Ongoing pain?
- Significant bruising to your arm?

8.0 Hand Injuries.

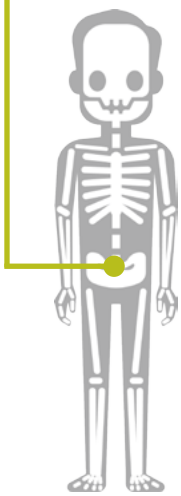


Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Broken fingers?
  - Which finger(s)?
  - ☐ Did you require surgery or treatment?
    - If so, what treatment?
  - ☐ Is the injury to your dominant hand?
  - ☐ Have you developed arthritis as a result?
  - ☐ Have you increased your risk of arthritis as a result?
  - ☐ Ongoing pain?
- ☐ Stretched or torn tendons or ligaments?
  - ☐ Ongoing pain?
  - ☐ Is the injury to your dominant hand?

9.0 Hip and Pelvis Injuries.

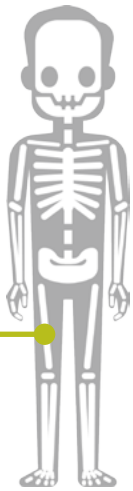


Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Broken hip, pelvis or coccyx (tailbone)?
  - ☐ Did you require any treatment? If so, what treatment?
- ☐ Stretched or torn tendons or ligaments?
  - ☐ Ongoing pain?
  - ☐ Trouble sitting?

10.0 Leg Injuries.

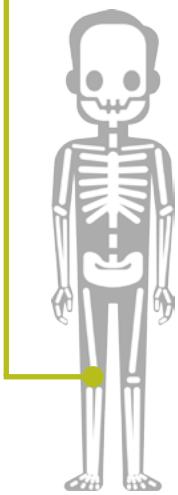


Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Leg fracture (including crush injuries) to your tibia (shinbone), fibular (calfbone) or femur (thigh bone)?
  - ☐ Did you have any period where you were unable to stand?
    - If so, how long? _____
  - ☐ Have you noticed a decrease in muscle mass?
  - ☐ Have you noticed a decrease in muscle strength?
  - ☐ Have you noticed a change in the way you walk?
  - ☐ Do you have reduced movement or functionality?
  - ☐ Have you suffered any scarring from treatment to correct the fracture?
- ☐ Stretched or torn tendons or ligaments?
  - ☐ Ongoing pain?
- ☐ Lacerations (cuts) to your leg(s)?
  - ☐ Did they require surgery?
- ☐ Significant bruising to your leg(s)?

11.0 Knee Injuries.

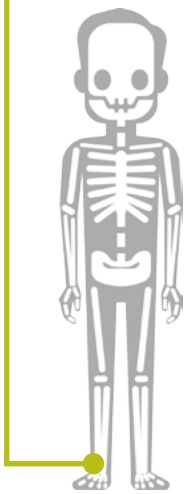


Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Dislocation of your knee?
- ☐ Torn or stretched ligaments?
- ☐ Torn cartilage or meniscus (disk of cartilage between your thigh and shinbone) ?
- ☐ Torn meniscus?
- ☐ Reduced knee movement?
- ☐ Reduced knee stability?
- ☐ Reduced knee strength?
- ☐ Sprained knee?
- ☐ Significant bruising?

12.0 Ankle Injuries.

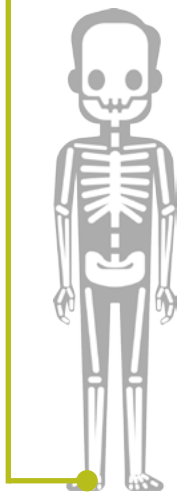


Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Broken ankle?
  - ☐ Did your require treatment?
  - If so, what was your treatment?
- ☐ Changes to walking style?
- ☐ Difficulty walking on stairs or uneven ground
- ☐ Torn or stretched ligaments?
- ☐ Sprained ankle?
- ☐ Significant bruising?

13.0 Foot Injuries.



Please tick all of the symptoms your have experienced after the accident.

Tick here:

- ☐ Broken toe(s)?
  - If so, how many toes? _____
  - ☐ Has this impacted on your ability to walk?
  - ☐ Has this impacted on your ability to perform daily activities?
- ☐ Torn or stretched ligaments?
- ☐ Laceration (cuts) to your foot?
- ☐ Significant bruising?

14.0 Psychological Symptoms.

Whilst the following questions don't appear to be directly related to a psychological injury, the ability to perform routine tasks can indicate that some mental harm is present.

14.1 PERSONAL CARE TASKS

Please respond to the following statements about changes to your personal care circumstances following the accident:

	NEVER	RARELY	SOMETIMES	VERY OFTEN	ALWAYS
I can live independently					
I require help to help prepare meals					
I require help to shower and dress myself					
I eat at least 3 times a day					
I am able to clean the house					

14.2 WORK RELATED TASKS

Please respond to the following statements about changes to your working circumstances following the accident:

	NEVER	RARELY	SOMETIMES	VERY OFTEN	ALWAYS
I am back doing the work task I was assigned prior to the accident					
I find work stressful					

14.3 SOCIAL INTERACTIONS

Please respond to the following statements about changes to your working circumstances following the accident:

	NEVER	RARELY	SOMETIMES	VERY OFTEN	ALWAYS
I am able to attend social events with ease					
I have lost interest in the activities that were once important to me or enjoyable					
I feel anxious about leaving the house					
I feel more secure if I have another person with me when leaving the house					
I find it easy meeting new people					
My personal relationships (i.e. with friends and family) feel strained					
I fight with my family and friends					
I feel more distant and isolated from other people					
I find it hard to feel love or affection for other people					

14.4 THOUGHT PROCESSES

Please respond to the following statements about changes to your working circumstances following the accident:

	NEVER	RARELY	SOMETIMES	VERY OFTEN	ALWAYS
I have repeated disturbing memories, thoughts or flashbacks of the accident					
I feel upset when I think of the accident					
I avoid situations or activities because they remind me of the accident					
I have night terrors of accidents					
I have trouble falling and/or staying asleep					