

**Please Check Any Of The Following Complaints
Which Were Sustained As A Result Of This Accident**

- | | | |
|---|---|--|
| <input type="checkbox"/> Headache | Difficulty With | <input type="checkbox"/> Loss Of Taste |
| <input type="checkbox"/> Heavy Head | <input type="checkbox"/> Standing | <input type="checkbox"/> Loss Of Smell |
| <input type="checkbox"/> Mental Dullness | <input type="checkbox"/> Walking | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Riding | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Loss Of Consciousness | <input type="checkbox"/> Bending | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Equilibrium Problems | <input type="checkbox"/> Lifting | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Dizziness | Pain Radiating Into | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Right Arm | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Left Arm | <input type="checkbox"/> Loss Of Sleep |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Right Leg | <input type="checkbox"/> Excess Sweating |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Left Leg | <input type="checkbox"/> Digestive Problem |
| <input type="checkbox"/> Neck ROM Restricted | <input type="checkbox"/> Right Shoulder | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Shoulder Pain (<input type="checkbox"/> L <input type="checkbox"/> R) | <input type="checkbox"/> Left Shoulder | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Middle Back Pain | <input type="checkbox"/> Right Hip (Buttocks) | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Left Hip (Buttocks) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Left Hip (Buttocks) | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Neck | Swollen |
| | <input type="checkbox"/> Base of Skull | <input type="checkbox"/> Hands <input type="checkbox"/> Feet |
| | Numbness In | |
| | <input type="checkbox"/> Fingers | |
| | <input type="checkbox"/> Toes | |
| | <input type="checkbox"/> Arms | |
| | <input type="checkbox"/> Legs | |
| | <input type="checkbox"/> Pain In Eyes | |
| | <input type="checkbox"/> Loss Of Focus | |
| | <input type="checkbox"/> Double Vision | |
| | <input type="checkbox"/> Ears Ringing | |

DOL _____ NAME _____ SIGNATURE _____