

SCHEDULE "A"

At Time Of:

<u>Accident</u>	<u>First Visit</u>	<u>Report</u>	<u>Patient Symptoms</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Balance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruises
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Buzzing and ringing in ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cuts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive sweating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye strain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes sensitive to light, loss of focus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Face flushed (red)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet cold
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands cold
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head seems heavy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head and shoulders feel heavy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head and shoulders feel tired
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light Headed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain with stiffness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental dullness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mid back pain or stiffness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain with stiffness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in arm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in legs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in fingers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in toes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulder blades
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pallor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pins and needles in arm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pins and needles in legs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restriction of neck motion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restriction of low back motion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other