



4. Where were you when the tornado hit your area?

Location (specific address or cross streets): \_\_\_\_\_

4a.  In a home (check one in **each of the 3 columns** describing the home)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> My family home | <input type="checkbox"/> Single family | <input type="checkbox"/> Brick          |
| <input type="checkbox"/> Other's home   | <input type="checkbox"/> Duplex        | <input type="checkbox"/> Wood/siding    |
|   | <input type="checkbox"/> Apartment     | <input type="checkbox"/> Stone/concrete |
|   | <input type="checkbox"/> Mobile home   |   |

4b.  Motor vehicle

- This vehicle was a:
- Car
  - Pickup/Van/Sports Utility
  - Greater than 4 wheels (semi, etc.)

Did you leave a home or building to escape the tornado?  Yes  No

**IF YOU WERE IN A MOTOR VEHICLE, GO TO QUESTION 9**

4c.  Outdoors

- Were you:
- in a ditch
  - under a bridge
  - Other—specify: \_\_\_\_\_

Did you get out of a motor vehicle because of the tornado?  Yes  No

Did you leave a home or building to escape the tornado?  Yes  No

**IF YOU WERE OUTDOORS, GO TO QUESTION 9**

4d.  Storm shelter (Check **one in each column** describing the shelter)

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Private               | <input type="checkbox"/> Above ground |
| <input type="checkbox"/> Public—specify: _____ | <input type="checkbox"/> Below ground |

4e.  Public/Commercial building (not storm shelter)—specify: \_\_\_\_\_

4f.  Other—specify: \_\_\_\_\_

5. Was the structure you were in damaged or destroyed during the tornado?  Yes  No

**IF YES, check the one that best describes the damage**

- Completely collapsed
- Some walls damaged and some standing
- Roof missing
- Roof damaged
- Only windows broken

6. Which room or part of the structure were you in when the tornado hit?

- |   |   |
|---|---|
| <input type="checkbox"/> Basement                 | <input type="checkbox"/> Closet               |
| <input type="checkbox"/> Underground shelter      | <input type="checkbox"/> Bedroom              |
| <input type="checkbox"/> Hallway                  | <input type="checkbox"/> Family/living room   |
| <input type="checkbox"/> Bathtub                  | <input type="checkbox"/> Kitchen              |
| <input type="checkbox"/> Bathroom, but not in tub | <input type="checkbox"/> Other—specify: _____ |

6a. What floor of the structure were you on?

- Basement  1<sup>st</sup> Floor  2<sup>nd</sup> Floor  3<sup>rd</sup> Floor  4<sup>th</sup> Floor or higher

7. If not in basement, were you in a room with exterior walls? (i.e., a wall with an outdoor surface)  
Yes      No      Unknown      Not Applicable

7a. **IF YES**, were there windows in the room?    Yes      No

8. Did you use something to protect yourself?      Yes      No

**If YES**, check all that apply:

- Mattress
- Some type of covering (blanket, pillow, coat, etc.)
- Heavy object (desk/table, etc.)
- Another person
- Other—specify: \_\_\_\_\_

9. What warnings/emergency alerts did you have of tornado activity in your area that afternoon?

**(Check all that apply)**

- Saw tornado at distance
- Weather changes suggestive of tornado
- Heard on standard radio
- Heard on weather band radio
- Saw on television
- Pager or phone
- Heard by word of mouth
- Heard siren
- Didn't know ahead of time
- Other—specify: \_\_\_\_\_

10. Were you trapped and rescued by others?      Yes      No

10a. **IF YES**, how long were you trapped?

- Less than 30 minutes
- 30-60 minutes
- More than 1 hour

11. How did you get to the hospital or emergency room?

- Ambulance
- Other public service vehicle (police, fire, Red Cross)  
specify: \_\_\_\_\_
- Private vehicle
- Other—specify: \_\_\_\_\_

12. How long was it from the time you were injured until you arrived at the hospital or emergency room?

- Less than 30 minutes
- 30-60 minutes
- More than 1 hour

13. Have you experienced any of the following?

	Since Tornado		Before Tornado	
	Yes	No	Yes	No
13a. Problems breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13b. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13c. Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13d. Disturbing dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13e. Jumpy or easily startled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13f. Recurring distressful thoughts of the tornado	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13g. Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**14. If you were injured, please complete the following table. List ALL of your injuries, even minor injuries**

- **TYPE OF INJURY** – list each injury: cuts, bruises, and abrasions; eye injuries; burns; brain injuries (includes concussions, skull fractures); fractures, dislocations, sprains, and strains; injuries to internal organs, blood vessels, nerves, ligaments, or tendons; and any other type of injury not listed.
- **LOCATION OF INJURY** – for each injury listed specify the part of the body that was injured.
- **INJURY DESCRIPTION/ MEDICAL TREATMENT** – To the best of your knowledge, describe each injury including the size of wound (if applicable), and/or medical treatment/medical procedures received for the injury. Examples: received stitches, wound cleaned and dressed, tetanus shot, X-rays, CAT Scan.
- **CAUSE** – for each injury listed specify the definite or most likely cause of the injury. Examples: struck by flying debris; walls fell in; blown by wind; struck by flying window glass; hit by furniture, board, etc.

TYPE OF INJURY	LOCATION OF INJURY	INJURY DESCRIPTION/MEDICAL TREATMENT	CAUSE
Example: Cuts	Front right forearm, left calf	3 inches-10 stitches, multiple small cuts and splinters, given antibiotics	Hit by flying wood
Example: Concussion	Head/brain	Lost consciousness, 2 min., had CAT Scan – negative	Struck on back of head by flying board
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

**15. Please list any other family members that received treatment at a hospital but did not receive one of these questionnaires.**

Name \_\_\_\_\_ Hospital \_\_\_\_\_  
 Name \_\_\_\_\_ Hospital \_\_\_\_\_  
 Name \_\_\_\_\_ Hospital \_\_\_\_\_

**16. At the time the tornado struck, did you have a pet at your residence?** Yes No  
**IF YES,** were any: Killed Injured Lost All are OK

**OPTIONAL:** *If you are willing to be contacted for further information, please sign here and write your name and phone number in the space provided.*

Signature: \_\_\_\_\_ Telephone number \_\_\_\_\_

**Thank you for providing this valuable information! Please return the survey in the enclosed postage-paid envelope.**

If you have further questions, contact: Injury Prevention Service—0307, Oklahoma State Dept of Health, 1000 NE 10<sup>th</sup> Street, Oklahoma City, OK 73117-1299, or call: 405/271-3430 or 1-800-522-0204.