



**Lightning Strike & Electric Shock Survivors International, Inc.**

**"Where Hope Begins"**

LSESSI, Inc.  
 P.O. Box 1156  
 Jacksonville, NC 28541  
 Phone (910) 346-4708  
 Fax (910) 346-4708  
 info@lightning-strike.org

[www.lightning-strike.org](http://www.lightning-strike.org)

## **Lightning Accidents Questionnaire**

*(To be completed by Lightning survivors only)*

**Please answer the following questions and check the appropriate boxes. Your answers will be kept confidential and used only for scientific research and lightning injuries. Please freely write your comments.. Please use the other side of this form or more pages if necessary.**

**Are you the eyewitness: Yes \_\_\_\_\_ No \_\_\_\_\_ or the survivor? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_**

**Profession: \_\_\_\_\_ Age: \_\_\_\_\_ Sex; Male \_\_\_\_\_ Female \_\_\_\_\_**

**Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_**

**Country: \_\_\_\_\_ Zip Code/ Plus4: \_\_\_\_\_ / \_\_\_\_\_**

**Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt. Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_**

**1. Are you a Mountaineer? Yes \_\_\_\_\_ No \_\_\_\_\_ Your Skill Level? \_\_Beginnner: \_\_ Average: \_\_ Good: \_\_ Excellent**

**2. When did the accident occur? Day: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_ Time: \_\_\_\_\_**

### **3. Where did the Lightning Strike occur?**

**Country: The precise location of the accident, (state, city, region , zone): \_\_\_\_\_**

**Mountain Region: On Summit \_\_\_\_\_; On Ridge \_\_\_\_\_; On Slope \_\_\_\_\_; Elevation \_\_\_\_\_; In bottom of canyon \_\_\_\_\_; Above Timberline \_\_\_\_\_**

**Open Field: Sport Field \_\_\_\_\_; On Shore \_\_\_\_\_; On Sea \_\_\_\_\_; Other area \_\_\_\_\_; Golf Course \_\_\_\_\_; Public Park \_\_\_\_\_ Parking Lot \_\_\_\_\_ Was there any other object nearby? \_\_\_\_\_**

**Covered Place: In a Forest \_\_\_\_\_; In a Tent \_\_\_\_\_; In a Hut \_\_\_\_\_; In a Building \_\_\_\_\_; Near a Building \_\_\_\_\_; Bus Stop \_\_\_\_\_ At Home \_\_\_\_\_ Total number (if any) of persons nearby, \_\_\_\_\_.**

### **4. Weather:**

**Before the Lightning Strike did you anticipate thunderstorms would come overhead? Yes \_\_\_\_\_ No \_\_\_\_\_ Did you notice any of the following characteristics of a thunderstorms?**

<b>Thunder</b>	<b>Lightning</b>	<b>Gust of Wind</b>	<b>Corona Manifestations</b>
<b>NONE</b> <input type="checkbox"/>	<b>NONE</b> <input type="checkbox"/>	<b>NONE</b> <input type="checkbox"/>	<b>BUZZING</b> <input type="checkbox"/> <b>FLAMES</b> <input type="checkbox"/>
<b>FAINT</b> <input type="checkbox"/>	<b>FAINT</b> <input type="checkbox"/>	<b>FAINT</b> <input type="checkbox"/>	<b>EFFECT ON HAIR</b> <input type="checkbox"/>
<b>STRONG</b> <input type="checkbox"/>	<b>STRONG</b> <input type="checkbox"/>	<b>STRONG</b> <input type="checkbox"/>	<b>SPARKS ON OBJECTS</b> <input type="checkbox"/>



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The lightning strike occurred during: Daytime \_\_\_\_\_ Nighttime \_\_\_\_\_

At the time of Lightning Strike:

The threatening weather dissipated quickly; Yes [ ] No [ ]

The threatening weather lasted about:

[ ] 10 Minutes [ ] 30 minutes [ ] More than 30 minutes

5. How did the strike occur and who were the victims?

A direct strike to one person: Yes [ ] No [ ]

If so was the person killed, or did they survive? \_\_\_\_\_

What was his or her posture at the time of the strike,( i.e.: sitting, standing, crouching)? \_\_\_\_\_

OR

Direct strikes to several people simultaneously: Yes [ ] No [ ]

If so the number of persons struck? \_\_\_\_\_

Individual situations of the victims:

Table with 4 columns: Injured People Nearby, Degree of Injury (heavy or slight), Posture when Struck, Distance from person directly struck. Rows for Victim #1 through Victim #6.

A side flash to one person [ ] OR Side flashes to several people simultaneously. [ ]

Number of persons: \_\_\_\_\_

Type of object struck: \_\_\_\_\_ Its Height: \_\_\_\_\_ Distance from the Victims: \_\_\_\_\_



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<i>Office use only</i>	<i>Identification Mark</i>	<i>Date</i>	<i>Country</i>	<i>Indicative Location</i>	<i>Page</i>

<i>Persons Struck By Side Flash</i>	<i>Killed or Survived</i>	<i>Posture at Time of Strike</i>	<i>Degree of Injury Slight, moderate, heavy</i>	<i>Distance from Directly Struck Object</i>
<i>Victim #1</i>				
<i>Victim #2</i>				
<i>Victim #3</i>				
<i>Victim #4</i>				

**6. Weather Conditions:**

<b>SKY</b>	<b>RAIN</b>	<b>SNOW</b>	<b>HAIL</b>	<b>WIND</b>
<i>CLEAR</i> <input type="checkbox"/>	<i>NONE</i> <input type="checkbox"/>	<i>NONE</i> <input type="checkbox"/>	<i>NONE</i> <input type="checkbox"/>	<i>NONE</i> <input type="checkbox"/>
<i>PARTLY CLEAR</i> <input type="checkbox"/>	<i>LIGHT</i> <input type="checkbox"/>	<i>LIGHT</i> <input type="checkbox"/>	<i>LIGHT</i> <input type="checkbox"/>	<i>LIGHT</i> <input type="checkbox"/>
<i>OVERCAST</i> <input type="checkbox"/>	<i>MEDIUM</i> <input type="checkbox"/>	<i>MEDIUM</i> <input type="checkbox"/>	<i>MEDIUM</i> <input type="checkbox"/>	<i>MEDIUM</i> <input type="checkbox"/>
<i>HEAVY OVERCAST</i> <input type="checkbox"/>	<i>HEAVY</i> <input type="checkbox"/>	<i>HEAVY</i> <input type="checkbox"/>	<i>HEAVY</i> <input type="checkbox"/>	<i>HEAVY</i> <input type="checkbox"/>

**7. Concerning the Victims(s):**

<i>Victim</i>	<i>Posture</i>	<i>Outer Clothing</i>	<i>Shoes</i>	<i>Headgear</i>	<i>Metal Pieces on Head</i>
<b>#1</b>					
<b>#2</b>					
<b>#3</b>					
<b>#4</b>					

<i>Carrying Long Objects</i>	<i>Loss of Consciousness</i>	<i>Medical care</i>
<i>Umbrella</i> <input type="checkbox"/> ; <i>Iron Rod</i> <input type="checkbox"/> ; <i>Other long object</i> <input type="checkbox"/> <i>Type of Object:</i> _____ <i>Length of object:</i> _____ <i>Composition of Object:</i> _____	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>  <i>Length of time</i> _____ _____	<i>Hospital Admission</i> <input type="checkbox"/>  <i>Out Patient</i> <input type="checkbox"/>  <i>No Medical Care</i> <input type="checkbox"/>



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## **Lightning Accidents Questionnaire (Cont'd)**

**Where your clothes or shoes damaged? Yes  No**

**If yes, what was the damage?** \_\_\_\_\_

**What do you remember about the lightning or the weather immediately before the lightning strike?** \_\_\_\_\_

**Would you agree to help us in the future by answering more questionnaires?**

**Yes  No**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**We encourage you to include additional comments and drawings as they would pertain to questions 5 thru 7. Please show the victims and there positions respective to the strike and the others involved or witnesses.**

**Thank You for your time and answers, they will help us help you and others!**