HEAD INJURY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

HOW AND WHEN DID YOU INJURE YOUR HEAD?

AUTO COLLISION (Check what your head hit or what hit your head)

- ☐ Windshield
- ☐ Dash board
- ☐ Air bag
- ☐ Steering wheel
- ☐ Rear window (pick-up truck)
- ☐ Side window or pillar
- ☐ Roof of vehicle or area above windshield
- ☐ Other _____

FALL

- ☐ Down stairs
- ☐ Slipped and fell, hitting head on:
- ☐ Concrete floor (no carpet)
- ☐ Wood floor (no carpet)
- ☐ Carpeted wood/concrete floor
- ☐ Stairs (Indicate if wood, concrete or carpet)
- ☐ Sidewalk, ground, pavement surface
- ☐ Horse-Bicycle-Motorcycle
- ☐ Off ladder or other structure. How much distance _____feet?
- ☐ Other:

BLOW TO HEAD

- ☐ Sports injury
- ☐ You hit your head on object
- ☐ Assault by another person
- ☐ Some type of object hit your head

OTHER (Please describe):

WHAT PART OF YOUR HEAD WAS HIT OR STRUCK?

☐ Front, ☐ Back, ☐ Left side, ☐ Right side, ☐ Top. ☐ Other (describe):

HEAD INJURY HISTORY CONT.

YES	NO	
☐	☐	Did you lose consciousness or black out for any time (seconds or minutes) after the head injury? If yes, indicate how long if you know (seconds/minutes): _____?
☐	☐	Have you lost any memory of the incident occurring before the head injury?
☐	☐	Have you lost any memory or has your memory been different since the head injury?
☐	☐	Did you have a lump or bruise after the head injury? Where? _____
☐	☐	Have you had any head injuries in your past (include childhood)?
☐	☐	Have you seen other doctors for this head injury?
☐	☐	Have you had any x-rays taken?
☐	☐	Have you had a CT or MRI scan taken of your head?

CONCUSSION QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

Please check any of the following boxes that correspond to any symptom(s) or other problems that you have had or observed since your injury. Circle specific words in section with more than one descriptive term.

YES	SYMPTOM DESCRIPTION	YES	SYMPTOM DESCRIPTION
☐	Headaches or migraines	☐	Blurry vision or other visual symptoms
☐	Dazed, stunned or lightheaded right after the accident	☐	Loss or absence of smell or taste
☐	Nausea and/or vomiting	☐	Difficulty handling multiple tasks
☐	Reduced drive or motivation	☐	More assertive
☐	Poor memory or forgetful	☐	Personality change
☐	Difficulty finishing tasks	☐	Hand tremors
☐	Abnormal anxiety, nervousness or irritability	☐	Ringing or buzzing sounds in your ears
☐	Seizure	☐	Less diplomatic than normal with other people
☐	Dizziness	☐	Mood swings
☐	Coordination, balance or walking difficulty	☐	Reduced attention span
☐	Anger outbursts or temper problems	☐	Blackouts
☐	Depression, sadness or helplessness	☐	Indifference to other people
☐	Fatigue	☐	More shallow relationships
☐	Difficulty or absence of ability to anticipate others	☐	Difficulty problem solving or making decisions
☐	Feeling mentally foggy or slowed down	☐	Less mental stamina
☐	Impaired sexual function	☐	Performance inconsistencies
☐	Difficulty reading, writing or speaking	☐	Can't remember numbers
☐	Impaired judgment	☐	Slower reaction times
☐	Need daytimer to remember appointments/activities	☐	Drowsiness
☐	Forgetful of recent information/conversations	☐	Trouble falling asleep (since injury)
☐	Forgetful about recent events or activities	☐	Sleeping more than usual
☐	Sensitive to noise or light	☐	Sleeping less than usual
☐	Need to repeat questions	☐	Other:

PLEASE ANSWER THE FOLLOWING QUESTIONS (Indicate if unknown)

A. What was the first event or thing that you remember after the accident? Describe the details about when you remembered it, persons that were involved in this event, if any, and other details: _____

_____

B. What was the last event or thing that you remember before the accident occurred? Describe details about when you remembered it, persons that were involved in this event, if any, and other details: _____

_____

C. ___ Yes, ___NO. Did you lose consciousness after the accident?
If yes, estimate how long _____? ___ Check if you do not know how long.

D. Did you have any lumps, bumps, abrasions, lacerations, cuts, or bruising to your head or face region? If yes, please describe them and where they occurred, if known, and what type of object that your head hit: _____

_____