Head Trauma Case History

Name: _____ DOB:_____Age now_____ Date_____

Address_____ City_____Province_____ Postal_____

Phone_____ referred by_____

Current medications:_____

_____

Allergies:_____

1. Date of accident/trauma _____

3. Describe the accident/trauma _____

_____

_____

_____

Type of Accident

3A. **Motor Vehicle**

Type of vehicle you were in: _____

If other vehicle(s) involved, list type(s) _____

Where were you sitting?

_____ Front Seat _____ Left Side _____ Middle

_____ Back Seat _____ Right Side _____ Unusual Position

Which restraints were used? (Check all that apply)

_____lap _____ shoulder _____car seat _____booster seat _____air bag

Speed of vehicle you were in _____

Speed of other object or vehicle _____

Did your vehicle hit another object? YES / NO

or did other vehicle hit your vehicle? YES / NO

If yes, where was your vehicle hit?

_____ Head On _____ Toward Front _____ Drivers Side

_____ Rear Ended _____ Toward Rear _____ Passenger Side

Did you experience whiplash? YES / NO

Did you hit your head? YES / NO

If yes, on what? _____

3B. **Other Accidents**

Type (ex Home Industrial Fall Hit by Object ,etc.) _____

Please describe: _____

_____

3C. **Toxic**

Type (ex: medication related, drug abuse, poison, etc.) _____

Please describe: _____

_____

3D. **Anoxic**

Type (ex: drowning, C02, anesthesia, cord around neck, etc.) _____

Please describe: _____

_____

3E. **Vascular**

Type (ex: stroke, aneurysm, hemorrhage, etc.) _____

Please describe: _____

_____

3F. **Other:** please explain_____
Please describe: _____
_____
_____

4. **Head Injury Description**
What part of your head was affected?

_____Forehead	_____Right Side	_____Top of head
_____Back of Head	_____Left Side	_____Face

Were you unconscious? YES / NO If so, for how long?_____
Comments_____
_____

5. **Initial Care**
Did you see a doctor concerning the accident? YES / NO
Whom did you see? _____
When? _____
Where? _____
What were you or your family told? _____
Comments: _____
_____
_____

6. **Subsequent/Other Professional Care**
What kind of professional care for your injuries/trauma have you received or are you receiving? Please add their name and phone number. We may need to contact them for better collaborative care.

Family Physician _____
Chiropractor _____
Neurologist _____
Neuropsychologist _____
Emergency Room Doctor _____
Occupational Therapist _____
Physical Therapist _____
Speech Therapist _____
Audiologist/Otolaryngologist _____
Psychologist _____
Physiatrist _____
Psychiatrist _____
Optometrist _____
Ophthalmologist _____
Osteopath _____
Massage Therapist _____
Other _____

7. **Symptoms immediately following the accident**

_____Double Vision	_____Headache	_____Loss of Memory
_____Blurred Vision	_____Pain In or Around Eyes	_____Vomiting
_____Dizziness	_____Restrictive Field of View	_____Loss of Balance
_____Disorientation	_____Flashes of Light	_____Restricted Motion

Comments_____
_____
_____
_____

8. **Difficulties Following Accident**

A. Work Related

Please describe: _____

_____

_____

_____

B. Hobbies/Avocational

Please describe: _____

_____

_____

C. Recreational/Social

Please describe: _____

_____

_____

D. Other

Please describe: _____

_____

_____

9. **Other Information**

Please take the time to share with us anything else that you feel is relevant:

_____

_____

_____

_____

_____

I authorize the release of medical and/or other information pertinent to my care to the insurance company in order for me to be reimbursed.

Signature: _____ **Date:** _____

10. **Subsequent Symptoms/Experiences**

Please consider each symptom and place "X" in all the columns that apply.
Place check under MIN if the symptom is only minimally present or MAX if the symptom is very significant.

Symptom	Was present before accident MIN	Was present before accident MAX	Had before accident and has worsened MIN	Had before accident and has worsened MAX	New symptom since accident MIN	New symptom since accident MAX
Blurred Vision, Distance Viewing ……...	____	____	____	____	____	____
Blurred Vision, Near Viewing ……...	____	____	____	____	____	____
Slow to shift focus, near to far to near ……	____	____	____	____	____	____
Difficulty taking notes…….	____	____	____	____	____	____
Putting or tugging sensation around eyes…….	____	____	____	____	____	____
Difficulty moving or turning eyes…….	____	____	____	____	____	____
Pain with movement of the eyes……...	____	____	____	____	____	____
Wandering eye…….	____	____	____	____	____	____
Double Vision…….	____	____	____	____	____	____
Loss of place while reading……...	____	____	____	____	____	____
Discomfort while reading…….	____	____	____	____	____	____
Unable to sustain near work/reading for adequate periods……...	____	____	____	____	____	____
General fatigue while reading……...	____	____	____	____	____	____
Eyes get tired while reading…….	____	____	____	____	____	____
Headaches ……...	____	____	____	____	____	____
Pain in or around eyes…….	____	____	____	____	____	____
Easily distracted……...	____	____	____	____	____	____
Decreased attention span ……...	____	____	____	____	____	____
Reduced concentration ability ……	____	____	____	____	____	____
Difficulty remembering what has been read …….	____	____	____	____	____	____
Difficulty remembering names of objects ……...	____	____	____	____	____	____
Difficulty remembering people's names ……...	____	____	____	____	____	____
Difficulty recalling information known in the past……...	____	____	____	____	____	____
Difficulty recognizing formerly familiar objects ……	____	____	____	____	____	____
Difficulty recognizing formerly familiar people ……...	____	____	____	____	____	____
Difficulty remembering things heard ……	____	____	____	____	____	____
Difficulty remembering things seen …….	____	____	____	____	____	____
Dizziness …….	____	____	____	____	____	____
Poor coordination …….	____	____	____	____	____	____
Clumsiness ……	____	____	____	____	____	____
Loss of balance ……	____	____	____	____	____	____
Poor eye-hand coordination ……...	____	____	____	____	____	____
Poor handwriting …….	____	____	____	____	____	____
Poor posture …….	____	____	____	____	____	____
Head tilt ……	____	____	____	____	____	____
Face turn ……	____	____	____	____	____	____
Covering, closing one eye …….	____	____	____	____	____	____
Disorientation ……	____	____	____	____	____	____
Get lost often ……...	____	____	____	____	____	____
Bothered by movement around you …….	____	____	____	____	____	____
Bothered by noises around you ……	____	____	____	____	____	____
Bothered by being touched ……...	____	____	____	____	____	____
Abnormal general fatigue ……	____	____	____	____	____	____
Reduced depth perception ……...	____	____	____	____	____	____
Light sensitivity ……	____	____	____	____	____	____
Flashes of light …….	____	____	____	____	____	____
Floaters in field of view ……	____	____	____	____	____	____
Restricted field of vision …….	____	____	____	____	____	____
Tunnel vision …….	____	____	____	____	____	____
"Curtain" billowing into field of view …….	____	____	____	____	____	____