Head Trauma Case History

Name: _____ DOB:_____Age now_____ Date_____

Address_____ City_____State_____ Zip_____

SSN_____ 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?

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:** _____

Continued on next page

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		Had before accident and has worsened		New symptom since accident	
	MIN	MAX	MIN	MAX	MIN	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						