

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, CO₂, 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		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	_____	_____	_____	_____	_____	_____