Head Trauma Case History

Name_____ Date:_____

1. **Date of accident/trauma:** _____

2. **Describe 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?

Lap Shoulder Car Seat Booster Seat Air Bag (Circle all that apply)

Speed of vehicle you were in_____

Speed of other vehicle or object_____

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 (example: Home, Industrial, Fall, Hit by Object, etc.) _____

_____

_____

3C. **Toxic** (example: Medication Related, Drug Abuse, Poison, etc.)_____

Describe: _____

3D. **Anoxic** (example: Drowning, CO, Anesthesia, Cord around Neck, etc.)_____

Describe: _____

3E. **Vascular** (example: Stroke, Aneurysm, Hemorrhage, etc.:_____

Describe: _____

3F. **Other**, please explain: _____

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:**

Type of professional care for your injuries/trauma:

	Received since trauma but not currently:	Currently Receiving:
Family Physician	_____	_____
Chiropractor	_____	_____
Neurologist	_____	_____
Neuropsychologist	_____	_____
Emergency Room Doctor	_____	_____
Occupational 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

Please consider each symptom and make a mark in each column that applies.
Add any notes that you feel may be helpful to Dr. Cecil.

SYMPTOMS	WAS PRESENT BEFORE ACCIDENT	HAD BEFORE, BUT NOW WORSE	NEW SINCE ACCIDENT
Decreased attention span	☐	☐	☐
Reduced concentration ability	☐	☐	☐
Difficulty remembering names of objects	☐	☐	☐
Difficulty remembering people's names	☐	☐	☐
Difficulty recalling information from past	☐	☐	☐
Difficulty recognizing familiar objects	☐	☐	☐
Difficulty recognizing familiar people	☐	☐	☐
Difficulty remembering things heard	☐	☐	☐
Difficulty remembering things seen	☐	☐	☐
Dizziness	☐	☐	☐
Poor coordination	☐	☐	☐
Clumsiness	☐	☐	☐
Loss of balance	☐	☐	☐
Poor hand-eye coordination	☐	☐	☐
Poor handwriting	☐	☐	☐
Poor posture	☐	☐	☐
Head tilt	☐	☐	☐
Face turn	☐	☐	☐
Covering or closing one eye	☐	☐	☐
Get lost often	☐	☐	☐
Disorientation	☐	☐	☐
Reduced depth perception	☐	☐	☐
Bothered by noises around you	☐	☐	☐
Bothered by being touched	☐	☐	☐
Bothered by movement around you	☐	☐	☐

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 anything else that you feel is relevant:

_____

_____

_____

_____

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