

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, 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?

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:** _____

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