Head Trauma History

Name:_____ SS#:_____

Emergency Contact:_____ Phone:_____

Date of Injury/Accident:_____

Type of Trauma:

- ☐ Car Accident
- ☐ Sports related concussion
- ☐ Fall
- ☐ Other Accident_____
- ☐ Stroke
- ☐ Aneurysm
- ☐ Brain Surgery
- ☐ Cerebral Hypoxia

Brief Description of the Injury

_____

_____

Have you missed work/school due to the injury/illness? ☐ YES ☐ NO

If yes, what date did you first miss work/school? _____/_____/_____

Are you currently working/back in school? ☐ YES ☐ NO

If yes, did you return to: ☐ Usual work/school activities ☐ Limited work/school activities

Is there a Visual Field Deficit? ☐ YES ☐ NO

If yes, which side of the field is affected? ☐ Left ☐ Right ☐ Both

Date of most recent medical exam _____ Name of Physician _____

Date of most recent vision exam _____ Name of Physician _____

Please check any of the following professionals that you have seen related to your injury

- ☐ Physiatrist
- ☐ Neurologist
- ☐ Psychologist
- ☐ Massage Therapist
- ☐ Chiropractor
- ☐ Psychiatrist
- ☐ Osteopath
- ☐ Physical Therapist
- ☐ Neuropsychologist
- ☐ Audiologist/Otolaryngologist
- ☐ Occupational Therapist
- ☐ Speech Therapist
- ☐ Ophthalmologist
- ☐ Family Physician
- ☐ Other_____

Name of Physicians you would like to receive a report regarding this evaluation

1. _____
2. _____
3. _____
4. _____