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Acquired Brain Injury Case History

Name: _____ Date: _____

1. Date of accident/trauma _____ 2. Referred by _____

3. Describe the accident/trauma _____

_____

_____

Type of Accident (Please fill out only the section that is relevant to your brain injury)

3A. **Motor Vehicle**

Type of vehicle you were in: _____
If other vehicle(s) involved, list type(s) _____
Where were you sitting?
_____ Front Driver _____ Front Passenger _____ Unusual Position
_____ Back Left Seat _____ Back Right Seat _____ Back Middle
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 Trauamtic 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. **Vascular or Anoxic**

Type (ex: stroke, aneurysm, hemorrhage, drowning, C02, anesthesia, cord around neck, 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 have had a medical diagnosis of brain injury (check box if true). My brain injury was: ____ years ago
☐ I suffered a brain injury without medical diagnosis (check box if true)
☐ I have NOT had a previous brain injury (check box if true)
your age _____ today's date: _____ your zip code: _____

Please check the most appropriate box, or circle the item number that best matches your observations. All information will be held in confidence. Thank you for your help!

SYMPTOM CHECKLIST ***Circle a number below:***

Please rate each behavior. **How often does each behavior occur?** (circle a number)	**Never**	**Seldom**	**Occasionally**	**Frequently**	**Always**
EYESIGHT CLARITY					
Distance vision blurred and not clear -- even with lenses	0	1	2	3	4
Near vision blurred and not clear -- even with lenses	0	1	2	3	4
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well to drive at night	0	1	2	3	4
VISUAL COMFORT					
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
DOUBLING					
Double vision -- especially when tired	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable – too much glare	0	1	2	3	4
Outdoor light too bright – have to use sunglasses	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
DRY EYES					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Have to rub the eyes a lot	0	1	2	3	4
DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4
PERIPHERAL VISION					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead--isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
READING					
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension / can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger not to lose place when reading	0	1	2	3	4