Bone & Joint Center
A Holland Hospital Physician Office

Head Injury Questionnaire

(Please use blue or black ink only)

Name: _____ Date: _____ DOB: _____ Age: _____

Sex: **M F** Height: _____ Weight: _____ Handedness: **R** **L** Date of Concussion: _____

Primary Care Physician: _____ Who Referred You: _____

Current Sport(s) _____

How did you sustain this injury? _____

_____

Can you describe your symptoms at the time of injury: (Blurred vision, headache, dizzy, amnesia before or after etc.)

_____

_____

If you have an athletic trainer at your school have you seen them for this injury? ☐ Yes ☐ No

If so, athletic trainer's name: _____

Please indicate below which symptoms if any that you are curently experiencing:

	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowisness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Suicidal thoughts	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

Office Use Only:

Weight:
_____

Blood Pressure:
_____

Height:
_____

Do the symptoms get worse with physical activity? ☐ Yes ☐ No

Do the symptoms get worse with mental activity? ☐ Yes ☐ No

What makes your symptoms worse? _____

What makes your symptoms better? _____

Concussion history:

_____Number of times diagnosed with a concussion (excluding current injury)

_____Total number of concussions

Diagnostic Studies: What tests have been completed? (List dates)

MRI _____ CT Scan _____ ImPACT testing _____

Past Medical History: Please mark any medical problem(s) that you had **prior to this concussion.**

☐ Migraine and/or frequent headaches ☐ Learning disability

☐ ADHD ☐ Motion sickness

☐ Anxiety/Depression ☐ Eye conditions (amblyopia, strabismus): _____

☐ Other medical illness (describe :) _____

Past Surgical History: Please list any **surgery** you have had in the past with the approximate date.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications: List the medications and dose that you take.

Name	Dosage	How Often	Name	Dosage	How Often
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Your Pharmacy: _____

Medication Allergies: List any medication allergy you have experienced. ☐ **No Allergies**

Name	Reaction	Name	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Social History:

What is your current marital status? ☐ Single ☐Married ☐ Divorced ☐Widowed

What is your current occupation? _____

What is your current work status? ☐Fulltime ☐ Part Time ☐ Limited Duty ☐ Unable to Work ☐Without Employment

The last date I worked was: _____ I have been on disability since: _____

Do you smoke tobacco? **YES** **NO** How many packs/day? _____ For how long? _____

Do you consume alcohol? **YES** **NO** How much? _____ How often? _____

Family History: Please mark any medical problems that exist in your family.

	Diabetes	**High Blood Pressure**	**Heart Disease**	**Stroke**	**Mental Illness**	**Cancer**	**Bleeding Disorder**	**Emphysema/ COPD**	**Other**
Father									
Mother									
Siblings									
Daughter(s)									
Son(s)									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									
Aunt									
Uncle									

Review of Systems for the Last Six Months: Circle "**yes**" or "**no**" for each sign/symptom.

	Yes	No
Psychology:		
Anxiety		
Depression		
Constitutional:		
Fatigue		
Malaise		
Neurology:		
Trouble with Balance		

	Yes	No
Trouble with Coordination		
Numbness		
Tingling		
Difficulty Falling/Staying Asleep		
Daytime Sleepiness		
Dizziness		
Headache		
Memory Loss		
Speech Abnormality		

For "yes" responses, which physician(s) is/are treating these conditions? _____

I hereby certify that the above information is correct to the best of my knowledge. I will not hold my physician(s) or any of their staff responsible for any errors or omissions I have made in completing this form.

Signature: _____ Date: _____