

Traumatic Brain Injury Service Patient Questionnaire

Name: _____

Exam Date: _____

Date of Birth: _____

Parent's Names, if minor:			
Who referred you to our office?	Name:		
	Address:		
	Specialty:		
What date did your accident, injury or stroke occur?			
How did your brain injury occur?			
What part of your head was injured or affected?		Check apply that apply <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Top of head <input type="checkbox"/> Face <input type="checkbox"/> Right side <input type="checkbox"/> Left side <input type="checkbox"/> Whiplash/Neck	
Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? Check one			<input type="checkbox"/> Open <input type="checkbox"/> Closed
Did you lose consciousness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long?	
Were you in a coma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long?	
Are you involved in a lawsuit/ workman's compensation case as a result of your injury?			<input type="checkbox"/> Yes <input type="checkbox"/> No
What were the symptoms immediately following the accident or injury? (Check all that apply)			
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Flashes of light
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Restricted motion	<input type="checkbox"/> Headache
<input type="checkbox"/> Pain in or around eyes	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Disorientation	<input type="checkbox"/> Neck pain/ Whiplash
<input type="checkbox"/> Restricted field of view	<input type="checkbox"/> Other (Please explain):		

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Visual History

Have you had a previous evaluation for this injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, doctor's name		Date of last evaluation	
What are the main visual symptoms being experience now?			
Do you wear bifocals?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear progressive lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your glasses work as well now as before the injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use new glasses, contact lens or optical devices after the injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
List devices recommended after the injury?			
Are they used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	
If no, why not?			
Were any additional tests, treatments or therapies recommended concerning your vision?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what?			
Did you undergo these treatments?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what were the results of the treatments?			
What other recommendations were made?			

Current Symptoms

Do you **currently** experience any of the following?

Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to concussion
Difficulty Changing Focus Far to Near	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to concussion
Difficulty Changing Focus Near to Far	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to concussion
Motion Sickness/ Car Sickness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to concussion
Movement of Objects in Environment Bothersome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to concussion
Tunnel Vision/ Loss of Visual Field	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to concussion
Holds Onto Things When Walking (People/Walls)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to concussion
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to concussion
Confusion/ Disorientation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to concussion
Bothered By Noises	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to concussion