



Patient: _____ Date: _____

Date of Accident: _____ Claim #: _____

Post-concussive / Closed-head Injury Questionnaire:

(IMPORTANT: Mark only symptoms you have had since the accident and not things that bothered you before.)

Never had	Had for awhile but went away	Currently have	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision / Double vision (circle one or both)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes sensitive to light
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in right ear / left ear / both ears (circle one)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	More sensitive to noise
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Balance problems (circle one or both)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unsteady gait or difficulty walking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty getting on/off escalators
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting (circle one or both)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased sense of smell / Increased sense of smell (circle one)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased sense of taste
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating / Forgetfulness (circle one or both)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel like in a fog or like the world is moving faster than you are
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impatient or get angry more often
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel depressed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of energy or get tired more easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased libido (sex drive)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems (turning words around, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Writing problems (omitting words, turning words around, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty doing math (adding up numbers, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:

Patient Signature _____