



## HEAD TRAUMA HISTORY

Developmental Vision & Rehabilitation

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Name

Date

Referred by: \_\_\_\_\_

### General Information

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Fax Number \_\_\_\_\_ E-Mail \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Age \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex M F Marital Status S M D W

If Married, Spouse's Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Name of Health Care Plan \_\_\_\_\_

Policy/Group Number \_\_\_\_\_

### Medical History

Explanation of injury \_\_\_\_\_ Date of injury \_\_\_\_\_

\_\_\_\_\_

Date of most recent medical examination \_\_\_\_\_ Name of physician \_\_\_\_\_

Medications currently taking \_\_\_\_\_

For what conditions \_\_\_\_\_

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

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Psychiatrist          | <input type="checkbox"/> Psychiatrist                 | <input type="checkbox"/> Family Physician       | <input type="checkbox"/> Neurologist     |
| <input type="checkbox"/> Osteopath             | <input type="checkbox"/> Speech Therapist             | <input type="checkbox"/> Psychologist           | <input type="checkbox"/> Chiropractor    |
| <input type="checkbox"/> Physical Therapist    | <input type="checkbox"/> Massage Therapist            | <input type="checkbox"/> Neuropsychologist      | <input type="checkbox"/> Ophthalmologist |
| <input type="checkbox"/> Emergency Room Doctor | <input type="checkbox"/> Audiologist/Otolaryngologist | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Other           |

Any history of the following, please check

	You	Family		You	Family
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye/Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>			

### Do You Experience Any of the Following, Please Check

	Yes	No		Yes	no
Brightness bothers you	<input type="checkbox"/>	<input type="checkbox"/>	One eye turns in or out	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in stores or malls	<input type="checkbox"/>	<input type="checkbox"/>	Squinting, covering or closing one eye	<input type="checkbox"/>	<input type="checkbox"/>
Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	Burning eyes	<input type="checkbox"/>	<input type="checkbox"/>
Head turns as reading across page	<input type="checkbox"/>	<input type="checkbox"/>	Tilting head during desk work	<input type="checkbox"/>	<input type="checkbox"/>
Eye ache	<input type="checkbox"/>	<input type="checkbox"/>	Eye drainage	<input type="checkbox"/>	<input type="checkbox"/>
Losing place often when reading	<input type="checkbox"/>	<input type="checkbox"/>	Fatigues easily	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Itching eyes	<input type="checkbox"/>	<input type="checkbox"/>
Using finger to keep place	<input type="checkbox"/>	<input type="checkbox"/>	Holding books too closely	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Delayed dressing skills	<input type="checkbox"/>	<input type="checkbox"/>
Short attention span for close work	<input type="checkbox"/>	<input type="checkbox"/>	Avoid near tasks	<input type="checkbox"/>	<input type="checkbox"/>
Eye redness	<input type="checkbox"/>	<input type="checkbox"/>	Dislike heights	<input type="checkbox"/>	<input type="checkbox"/>
Skipping words frequently when reading	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty following series of directions	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Awkward, poor balance	<input type="checkbox"/>	<input type="checkbox"/>
Orient drawing poorly on page	<input type="checkbox"/>	<input type="checkbox"/>	Difficult using both sides of body together	<input type="checkbox"/>	<input type="checkbox"/>

### Motor Vehicle Accident

Type of vehicle you were in \_\_\_\_\_ Other vehicles involved \_\_\_\_\_

Were you sitting in  Front seat  Back seat  Middle

Seat relative location  Left side  Right side  Unusual position

Which restraints were used  Lap  Shoulder  Car seat  Booster seat  Air bag

Speed of vehicle you were in \_\_\_\_\_ Speed of other vehicle or object \_\_\_\_\_

Did your vehicle hit another object  Yes  No

Or, did the other vehicle hit your vehicle  Yes  No

If yes where was your vehicle hit  Head on  Toward front  Driver's side

Rear ended  Toward rear  Passenger's side

Did you experience whiplash  Yes  No

Did you hit your head  Yes  No

If yes, on what \_\_\_\_\_