

Symptoms of Brain and Bodily Dysfunction

Patient Name _____

Date: _____

Date of Injury (DOI) _____

Place a check on the line in the first (1st) column if you had any of these symptoms **before** the collision.
 Place a check on the line in the second (2ⁿ^d) column if you had any of these symptoms **after** the collision.
 Place a check on the line in the third (3^r^d) column if you are experiencing any of these symptoms **today**.
Leave the last column blank (for office use only).

Thinking / Remembering

	Before DOI	After DOI	Today	Today 0/10
Difficulty thinking clearly	_____	_____	_____	_____
Thinking slowed down and/or mentally fatigued	_____	_____	_____	_____
Difficulty concentrating and/or staying focused	_____	_____	_____	_____
Difficulty staying organized	_____	_____	_____	_____
Difficulty learning and/or remembering new information	_____	_____	_____	_____
Short term memory loss	_____	_____	_____	_____
Long term memory loss	_____	_____	_____	_____
Difficulty finding words and/or expressing yourself	_____	_____	_____	_____
Difficulty with reading and/or comprehension	_____	_____	_____	_____
Difficulty with numbers and/or forgetting numbers	_____	_____	_____	_____
Difficulty recognizing people	_____	_____	_____	_____
Difficulty recognizing where you are	_____	_____	_____	_____
Missing periods of time	_____	_____	_____	_____
Loss of insight and/or poor judgment	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Sleep

	Before DOI	After DOI	Today	Today 0/10
Sleeping more than usual	_____	_____	_____	_____
Sleeping less than usual	_____	_____	_____	_____
Having trouble falling asleep	_____	_____	_____	_____
Having trouble staying asleep (added to list)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

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Physical

	Before DOI	After DOI	Today	Today 0/10
Physically fatigued and/or fatiguing more easily	_____	_____	_____	_____
Headache	_____	_____	_____	_____
Fuzzy, blurry and/or double vision	_____	_____	_____	_____
Nausea and/or vomiting	_____	_____	_____	_____
Dizziness and/or light headed	_____	_____	_____	_____
Balance problems / feelings of falling and/or spinning	_____	_____	_____	_____
Difficulty speaking and/or writing	_____	_____	_____	_____
Decrease or loss of smell	_____	_____	_____	_____
Decrease or loss of taste	_____	_____	_____	_____
Sensitivity to noise, and/or easily upset / irritated by loud noise	_____	_____	_____	_____
Sensitivity to light, and/or easily upset / irritated by bright light	_____	_____	_____	_____
Intolerance to heat and/or cold	_____	_____	_____	_____

Emotion / Mood / Affect

	Before DOI	After DOI	Today	Today 0/10
Feeling more emotional and/or emotionally fragile	_____	_____	_____	_____
Feeling nervous / restlessness and/or anxious	_____	_____	_____	_____
Feeling irritable / frustrated / and/or uncooperative	_____	_____	_____	_____
Feeling impatient / angry / and/or aggressive	_____	_____	_____	_____
Feeling less / lacking emotion	_____	_____	_____	_____
Feeling apathetic / without motivation	_____	_____	_____	_____
Feeling depressed, sad and/or tearful	_____	_____	_____	_____
Personality changes	_____	_____	_____	_____
Withdrawal from family / friends	_____	_____	_____	_____
Relationship difficulties	_____	_____	_____	_____
Neglecting personal hygiene	_____	_____	_____	_____
Resistant to health care	_____	_____	_____	_____
Socially Inappropriate behavior	_____	_____	_____	_____
Unusual sexual behavior and/or loss of libido	_____	_____	_____	_____

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Head, Face and Neck Pain	Before DOI	After DOI	Today	Today 0/10
Headache - right/left	_____	_____	_____	_____
Face - right/left	_____	_____	_____	_____
Upper Neck - right/left/midline	_____	_____	_____	_____
Lower Neck - right/left/midline	_____	_____	_____	_____

Back Pain	Before DOI	After DOI	Today	Today 0/10
Upper Back - right/left/midline	_____	_____	_____	_____
Middle Back - right/left/midline	_____	_____	_____	_____
Lower Back - right/left/midline	_____	_____	_____	_____
Pelvis - right/left/midline	_____	_____	_____	_____

Upper Body Pain	Before DOI	After DOI	Today	Today 0/10
Shoulders - right/left/front/back	_____	_____	_____	_____
Arms - right/left	_____	_____	_____	_____
Hands - right/left	_____	_____	_____	_____
Fingers - right/left	_____	_____	_____	_____

Lower Body Pain	Before DOI	After DOI	Today	Today 0/10
Hips - right/left	_____	_____	_____	_____
Thighs - right/left	_____	_____	_____	_____
Legs - right/left	_____	_____	_____	_____
Feet - right/left	_____	_____	_____	_____

Thank you for taking the time to fill out this form as completely as possible. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental and emotional state.

Patient's Signature _____

Date _____

Guardian's Signature _____

Date _____