

Head Injury Questionnaire

This questionnaire is designed to determine whether you have ever had a significant injury to your brain. Please read the questions carefully and think carefully about your history. It is common for people to forget head injuries, car accidents, minor falls, etc. when they are not followed by a loss of consciousness or significant impairment.

Event	Yes	No	List events and dates	Low ← <u>Severity</u> → High
Have you ever had an injury involving an impact to your head?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____ _____
Were you ever in a motor vehicle, skate board, skiing, bike or other accident?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____ _____
Were you told that you fell as a child (down stairs, off a table or chair, at a park?)			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____ _____
Ever been in a fight, been beaten or attacked, passed out from alcohol?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____ _____

Symptoms persisting after event	Yes	No	Describe <u>ONLY</u> head injury related symptoms – intensity, duration, affect on life tasks, i.e. work/school	Low ← Severity → High
Headache – tension and/or migraine				1 2 3 4 5 6 7 8 9 10
Tinnitus				1 2 3 4 5 6 7 8 9 10
Light headed				1 2 3 4 5 6 7 8 9 10
Impaired memory				1 2 3 4 5 6 7 8 9 10
Reduced attention span				1 2 3 4 5 6 7 8 9 10
Easily distractible				1 2 3 4 5 6 7 8 9 10
Impaired comprehension				1 2 3 4 5 6 7 8 9 10
Forgetful				1 2 3 4 5 6 7 8 9 10
Frustration				1 2 3 4 5 6 7 8 9 10
Problems with logical thinking				1 2 3 4 5 6 7 8 9 10
Trouble with abstract concepts				1 2 3 4 5 6 7 8 9 10
Anxiety				1 2 3 4 5 6 7 8 9 10
Depression				1 2 3 4 5 6 7 8 9 10
Insomnia				1 2 3 4 5 6 7 8 9 10
Apathy				1 2 3 4 5 6 7 8 9 10
Fatigue				1 2 3 4 5 6 7 8 9 10
Irritability				1 2 3 4 5 6 7 8 9 10
Angry outbursts				1 2 3 4 5 6 7 8 9 10
Mood swings				1 2 3 4 5 6 7 8 9 10
Hyper acute or diminished senses				1 2 3 4 5 6 7 8 9 10
Dizzy				1 2 3 4 5 6 7 8 9 10
Reduced libido				1 2 3 4 5 6 7 8 9 10
Intolerance for alcohol or caffeine				1 2 3 4 5 6 7 8 9 10
Reduced motivation				1 2 3 4 5 6 7 8 9 10