HURT YOUR HEAD. WHAT SHOULD YOU DO?

POST-CONCUSSION SYMPTOM QUESTIONNAIRE

1. Immediately visit your physician or your nearest Emergency Room or Urgent Care Facility.
2. Completing the below standardized questionnaire may help your doctor’s examination.

How did your injury happen? __________________________________________________________

**Cause of Accident** (Check One):

<table>
<thead>
<tr>
<th>Motor Vehicle</th>
<th>Motor Vehicle/Pedestrian</th>
<th>Fall</th>
<th>Assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sport(specify)</td>
<td>Other(specify)</td>
<td></td>
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</tbody>
</table>

**Did you lose consciousness?** (Circle One): YES NO Duration: __________________________

After a head injury or accident some people experience a variety of symptoms. Use this checklist to rate how severe your symptoms are after your head injury. For each one, please circle the number closest to your answer.

**Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:**

- Headaches .............................................................. 0 1 2 3 4
- Feelings of Dizziness .................................................... 0 1 2 3 4
- Nausea and/or Vomiting ............................................... 0 1 2 3 4
- Noise Sensitivity, easily upset by loud noise .................... 0 1 2 3 4
- Sleep Disturbance .................................................... 0 1 2 3 4
- Fatigue, tiring more easily .......................................... 0 1 2 3 4
- Being Irritable, easily angered .................................... 0 1 2 3 4
- Feeling Depressed or Tearful ....................................... 0 1 2 3 4
- Feeling Frustrated or Impatient ................................... 0 1 2 3 4
- Forgetfulness, poor memory ....................................... 0 1 2 3 4
- Poor Concentration ................................................... 0 1 2 3 4
- Taking Longer to Think ............................................. 0 1 2 3 4
- Blurred Vision .......................................................... 0 1 2 3 4
- Light Sensitivity, Easily upset by bright light .................. 0 1 2 3 4
- Double Vision .......................................................... 0 1 2 3 4
- Restlessness ............................................................ 0 1 2 3 4

**Are you experiencing any other difficulties?**

1. .................................................................................. 0 1 2 3 4
2. .................................................................................. 0 1 2 3 4

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