E: Head injury symptoms form

For completion by the parent/guardian in consultation with the injured child as appropriate.

Name of child

Date of accident:

[month, day, year]

If your answer is "yes" to any of the following questions, please provide as much detail as possible. For example, how **often** is this a problem? How severe is the symptom when it occurs? How long does the symptom last? Generally speaking, has this symptom improved over time?

Did the child experience any of the following symptoms after the accident?

Loss of consciousness ☐ **Yes** ☐ **No**

Inability to recall the accident and/or subsequent events ☐ **Yes** ☐ **No**

Headaches ☐ **Yes** ☐ **No**

Dizziness ☐ **Yes** ☐ **No**

Blurred vision ☐ **Yes** ☐ **No**

Excessive fatigue ☐ **Yes** ☐ **No**

Problems with memory ☐ **Yes** ☐ **No**

E: Head injury symptoms form (cont)

Problems with concentration ☐ Yes ☐ No

Problems with judgment ☐ Yes ☐ No

Problems with social relationships ☐ Yes ☐ No

Problems with behaviour ☐ Yes ☐ No

Problems with his/her academic performance ☐ Yes ☐ No

Do you wish to add any further comments? ☐ Yes ☐ No

Date

Signature **Signature**

Print Name **Print Name**