ALL ABOUT CHOICE MEDICAL P.C. NEUROSCIENCE DEPARTMENT

IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS BELOW

Please Call to schedule an appointment: 718-587-9997

Problems developed as a consequence of your accident

Patient Name:_____ _____ Date:_____/_____/_____

Please read below and mark any emotional, behavioral and/or cognitive symptoms that may have arisen as a consequence of the recent accident.

I. EMOTIONAL/BEHAVIORAL PROBLEMS:

Since the accident of ___/ _____/ _____

1. I often feel angry and or irritable _____ Y ☐ N ☐
2. I often feel frightened _____ Y ☐ N ☐
3. I often feel sad and/or hopeless _____ Y ☐ N ☐
4. I often have sleeping problems: wake up several times, hard to get asleep _____ Y ☐ N ☐
5. I often think about the accident, a future possible accident, or other accidents _____ Y ☐ N ☐
6. My appetite has changed _____ Y ☐ N ☐
7. I have been experiencing dizziness _____ Y ☐ N ☐
8. I have been experiencing recurrent headaches _____ Y ☐ N ☐

II. COGNITIVE PROBLEMS:

Since the accident of _____/_____/_____

1. I feel forgetful and my memory has gotten worse _____ Y ☐ N ☐
2. I feel easily distracted and can't concentrate for long periods of time _____ Y ☐ N ☐
3. I often have problems with directions and even get lost _____ Y ☐ N ☐
4. I often struggle to do different things at the same time _____ Y ☐ N ☐
5. I often lose track in a conversation or just forget what I was going to do _____ Y ☐ N ☐
6. I often try to say something but can't find the words _____ Y ☐ N ☐

III HEAD COMPROMISE:

Since the accident of _____/____/_____

1. I hit my Head or my neck _____ Y ☐ N ☐
2. I lost Consciousness _____ Y ☐ N ☐
3. I had a whiplash _____ Y ☐ N ☐

Signature: _____