February 2019

CHIROPRACTIC NEW PATIENT - INTAKE FORM

PATIENT HEALTH RECORD

As a full spectrum chiropractic clinic; we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Please complete this document so we are better able to address your specific health concerns and challenges. Chiropractic is great for a variety of reasons. Pain relief, injury recovery, mobility improvement, and correction of whatever is malfunctioning in the body, are all areas of healthcare our doctors are capable of treating.

Were you aware that:
◯ Y ◯ N - Doctors of Chiropractic work with the nervous system?
◯ Y ◯ N - The nervous system controls all bodily functions and system?

Full Name: ______________________ ***M / F*** ***AHC #:*** ______________

Date of Birth (M/D/Y): ____________ **Age:** _____ **Occupation:** ______________

Address: ______________________ **City:** __________ **Prov:** _____ **Postal Code:** _______

Home phone: ______________ **Cell phone:** ______________ **Work Phone:** ______________

◯ **Single** ◯ **Married** ◯ **Divorced** ◯ **Separated** ◯ **Widowed** **Children? Y / N** **How Many?:** _______

Name of Spouse: ______________________ **Phone Number:** ______________

Alternate Emergency Contact: ______________________ **Phone Number:** ______________

If under 18, Name of Parents: ______________________

Do you consent to emails regarding appointment reminders and clinic/health information? ___ Yes ___ No

Email: ______________________ **Initials:** __________

How were you referred to Beacon Hill Chiropractic & Massage?

◯ Online ◯ Website ◯ Walk by ◯ Lives in area ◯ Other: _______ ◯ Person: ______________

◯ Current patient: ______________

Experience with Chiropractic

Have you ever been adjusted by a Chiropractor before? ◯ Yes ◯ No How long ago? ______________

Doctor's name? ______________ Reason for visit? ______________

REASON FOR THIS VISIT

Is this visit due to or in any way related to: ◯ Job ◯ Sport ◯ Car accident ◯ Fall ◯ Chronic discomfort ◯ Injury ◯ Other

If job related, have you reported your accident to your employer? Y / N **Will this visit be part of a WCB claim?** Y / N

If motor vehicle related, will this visit be part of a MVA claim? Y / N

Please describe the reason for your visit: ______________________

When did this condition begin? ______________ Has it gotten: ◯ Worse ◯ Better ◯ Stayed the same ◯ Comes/goes

Does this condition interfere with: ◯ Work/School ◯ Sleep ◯ Daily routine ◯ Exercise/Athletics

Please explain: ______________________

Have you seen anyone else for this condition? Doctor/clinician's name: ______________________

Type of treatment: ______________ Result: ______________

FULL NAME: ____

Please **CHECK** any current/past conditions

CARDIOVASCULAR
- ◯ Angina
- ◯ Blood clots
- ◯ Blood pressure: HIGH
- ◯ Blood pressure: LOW
- ◯ Congenital heart defect
- ◯ Hardening of arteries
- ◯ Heart attack
- ◯ Heart murmur
- ◯ Heart surgery
- ◯ Hemophilia
- ◯ Pace maker
- ◯ Poor circulation
- ◯ Stroke
- ◯ Thrombosis
- ◯ Varicose veins

RESPIRATORY
- ◯ Asthma
- ◯ Chest pain
- ◯ Difficulty breathing
- ◯ Emphysema (short of breath)
- ◯ Pneumonia
- ◯ Pulmonary hypertension
- ◯ Tuberculosis

GASTROINTESTINAL
- ◯ Constipation
- ◯ Crohn's or Colitis
- ◯ Digestive problems
- ◯ Gallbladder/Jaundice
- ◯ IBS or IBD
- ◯ Nausea/Vomiting
- ◯ Ulcers

MUSCLE/BONE/JOINT/DISC
- ◯ Ankle swelling
- ◯ Arthritis
- ◯ Back pain
- ◯ Bursitis
- ◯ Cortisone injections
- ◯ Degenerative disease
- ◯ Fractures/Breaks: ____________________
- ◯ Inflammation
- ◯ Osteopenia
- ◯ Osteoporosis
- ◯ Plates/Pins
- ◯ Rheumatoid arthritis
- ◯ Sciatica
- ◯ Scoliosis
- ◯ Pain b/w shoulder blades
- ◯ Spinal disc problems
- ◯ Sprain/Strain
- ◯ Trauma/Falls
- ◯ Weakness/Instability

HEAD & NECK
- ◯ Dizziness
- ◯ Ear infection
- ◯ Headache
- ◯ Hearing loss
- ◯ Neck pain
- ◯ Difficulty with swallowing
- ◯ Ringing in ears (tinnitus)
- ◯ Sinus problems
- ◯ Sleep loss
- ◯ TMJ disorder
- ◯ Vertigo
- ◯ Vision problems
- ◯ Whiplash

NEUROLOGICAL
- ◯ Alzheimer's/dimentia
- ◯ Brain injury
- ◯ Cerebral palsy
- ◯ Epilepsy
- ◯ Fainting
- ◯ Migraines
- ◯ Loss of motor control
- ◯ Meningitis
- ◯ Multiple Sclerosis (MS)
- ◯ Narcolepsy/Insomnia
- ◯ Nerve damage: ________
- ◯ Numbness in arms/legs/ hands/feet/__________
- ◯ Parkinson's/ Seizures

SKIN CONDITIONS
- ◯ Keloid/Scarring
- ◯ Psoriasis
- ◯ Shingles
- ◯ Warts

WOMEN ONLY
- ◯ Cramps/back pain
- ◯ Infertility issues
- ◯ Irregular cycles
- ◯ Menopause
- ◯ Miscarriage
- ◯ New mother
- ◯ Nursing
- ◯ Painful menstruation
- ◯ Pregnant

DIAGNOSED CONDITIONS
- ◯ ADD/ADHD
- ◯ Autoimmune disease
- ◯ Cancer: ______________ ____________________ (radiation/chemotherapy)
- ◯ Diabetes (I / II)
- ◯ Hepatitis
- ◯ HIV/AIDS
- ◯ Hypertension
- ◯ Infectious disease: ____________________
- ◯ Kidney disease
- ◯ Raynaud's
- ◯ Thyroid problems
- ◯ Tuberculosis
- ◯ Urinary system issues
- ◯ Other: ______________

MENTAL HEALTH
- ◯ Alcohol/drug abuse
- ◯ Anxiety
- ◯ Bipolar disorder
- ◯ Depression
- ◯ Eating disorder
- ◯ Panic attacks
- ◯ Postpartum depression
- ◯ Psychiatric issues
- ◯ PTSD
- ◯ Stress

ALLERGIES

Allergic to: ______________ ______________

Reaction: ______________ ______________

◯ EpiPen? YES / NO

MEDICATIONS/SUPPLEMENTS

Some drugs can cause neuro-musculoskeletal symptoms. It is important for our chiropractors to know what medications you are currently taking. Symptoms you present in clinic may be related to these medications. If you are unsure of your medications it is imperative that you let us know at your next visit.

- ◯ Acid reducers
- ◯ Antidepressants
- ◯ Birth control
- ◯ Blood pressure meds
- ◯ Blood thinners
- ◯ Insulin
- ◯ Muscle relaxers
- ◯ Pain killers (NSAIDS/Ibuprofen)
- ◯ Stimulants

Medications	Dosage	Duration	Reason

Nutritional supplements	Dosage	Duration	Reason

FULL NAME: ______________________________

FAMILY HEALTH HISTORY

◯ Arthritis ◯ Depression ◯ Digestive issues/IBS ◯ High blood pressure ◯ Osteoporosis
◯ Cancer ◯ Diabetes ◯ Heart disease ◯ Multiple sclerosis ◯ Stroke

HEALTH & LIFESTYLE

	YES	NO	Frequency
Smoking			/day
Alcohol			/day
Coffee			/day
Cannabis			/day
CBD Oil			/day

Please note that treatment will be withheld for any patient under the influence of alcohol or non-prescription drugs

*How frequently do you consume/participate in the following **per day**?*						
	0	1-2	3-4	5-6	7-9	10+
Glasses of water						
Fruits/vegetables						
Sugary treats						
Salty treats						

*How frequently do you participate in the following **per week**?*					
	0x	1x	2-3x	4-5x	6+
Cardio exercise					
Strength training					

Describe your sleep habits: ______________________________

How would you describe your energy? ______________________________

Do you wear foot support/orthotics? ◯ Yes ◯ No

STRESS HISTORY – please list your current/past stressors

Biggest PHYSICAL stressors: ______________________________

Most significant CHEMICAL/NUTRITIONAL stressors: ______________________________

Source of MENTAL/EMOTIONAL stress: ______________________________

Past motor vehicle accident? ◯ Yes ◯ No Date of accident: ______________________________

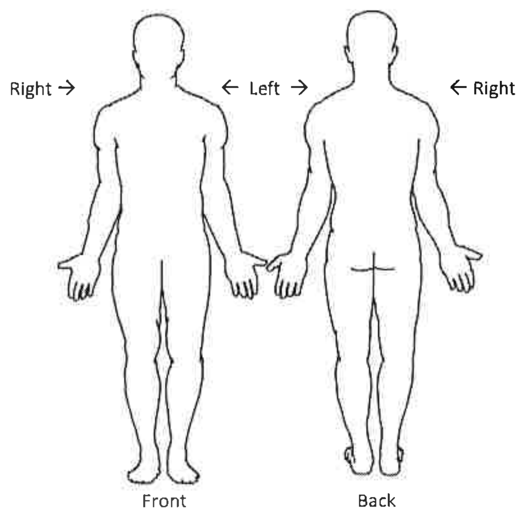
Past surgeries? ◯ Yes ◯ No Please list: ______________________________

____

PAIN/DISCOMFORT DIAGRAM:

Please mark these diagrams according to where you feel pain. Please also indicate which sensations you feel by referring to the key below:

KEY
///// Stabbing
XXXX Aching
Burning
>>>> Pins/Needles
0000 Numbness



PLEASE CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

0-3 – No pain; Mild pain **4-7** – Moderate pain; medication required **8-10** – Severe pain; daily life impacted

SPECIFIC PATIENT INFORMATION FOR WCB CLAIM

WCB Claim Number: ______________________________

Date of Injury (Y/M/D): / / **Time:** __________ **am/pm** **Time lost off work? YES/NO**

Address Where You Were Injured: ______________________________

Have you filled out an Incident Report with your Employer YES/NO

Has this injury been reported to WCB? **YES/NO** Are you in contact with your case worker? **YES/NO**

If no, please fill out Workers Report of Injury C060 before continuing

Worker's Information

Surname:	Given Names:	DOB (Y/M/D) / /
Address:		Postal Code:
Alberta Healthcare Number:	Telephone Number:	

Employment Information

Company Name:		
Address:		Postal Code:
Position/Title:	Supervisor/ Case Worker:	Telephone Number:
Job Description:		
Which best describes your **pre-injury** job requirements? ( ) Sedentary/Limited ( ) Light ( ) Medium ( ) Heavy ( ) Very heavy		
Which best describes your **post-injury** job requirements? ( ) Sedentary/Limited ( ) Light ( ) Medium ( ) Heavy ( ) Very heavy		
Are you currently working? **YES/NO** If so, are you currently able to perform your regular work duties? **YES/NO**		

Is modified or alternate work available for you at your place of employment? **YES/NO**
If yes, please explain:

___

___

___

Please list any specific job requirements and how your accident is affecting your ability to perform them:

___

___

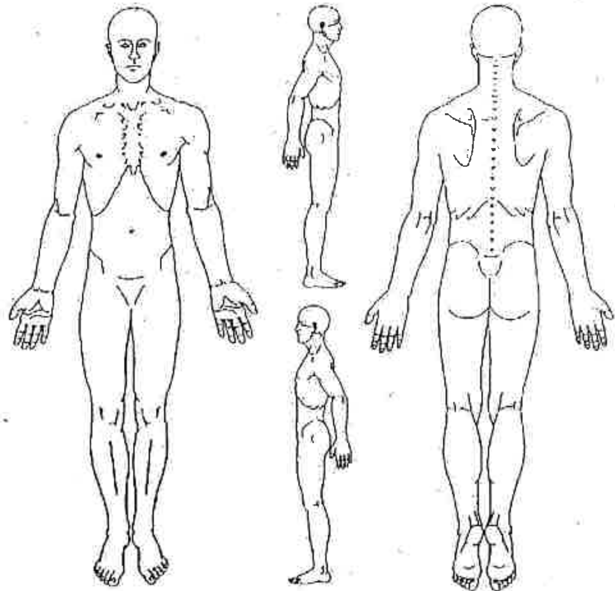
___

Injury Information

Describe what happened to you at the time of your injury (how and where):

Have you been unable to work or missed time from work due to injury? **YES/NO**
If yes please list dates and times below

Describe your complaint (site and symptoms including cuts/bruises):



USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATIONS OF YOUR SENSATIONS RIGHT NOW
KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES **S** = STABBING **O** = OTHER

Please check if you are experiencing any of the following symptoms:

( ) headache
( ) neck pain/stiffness
( ) low back pain
( ) mid back pain
( ) eyes sensitive to light
( ) pain behind eyes
( ) dizziness
( ) fainting
( ) ringing/buzzing ears
( ) loss of balance
( ) other ______________________

( ) loss of smell
( ) loss of taste
( ) loss of memory
( ) fatigue
( ) tension
( ) shortness of breath
( ) irritability
( ) depression
( ) sleeping problems
( ) numbness in toes

( ) numbness in fingers
( ) cold hands
( ) cold feet
( ) diarrhea
( ) constipation
( ) chest pain
( ) nervousness
( ) cold sweats
( ) anxious

Prior to the accident have you **ever** had any of the symptoms similar to what you are experiencing now? **YES/NO**
If yes please explain (include any past falls, injuries, motor vehicle accidents, operations):
____
____

Do you notice any activities of your home daily routine that are different **now** than from **before** the accident? **YES/NO**
Do you notice any activities of your work daily routine that are different **now** than from **before** the accident? **YES/NO**
Activities that you are **unable** to do: ______________________
Activities that are **painful**: ______________________
Activities that are **difficult**: ______________________

Did you seek any medical help after the injury or have you seen anyone regarding this WBC claim? **YES/NO**
If Yes please check: ( ) Chiropractic ( ) Physiotherapy ( ) Medical doctor ( ) Other ____________
How did you get there? ____________________ Date seen: ____________________
Were you examined? **YES/NO**
Were X-rays taken? **YES/NO** Body Part: ______________________
What treatment was given? ( ) bed rest ( ) brace ( ) adjustments ( ) physiotherapy ( ) medications ( ) other
Date of last treatment: ______________________

Patient Signature: ______________________

Doctors Signature: ______________________

Date: ______________________

NECK PAIN AND DISABILITY INDEX (Vernon-Mior)

Patient Name: ______________________ File#: __________ Date: ____________

PLEASE READ THE INSTRUCTIONS:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only one box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

Section 1 – PAIN INTENSITY
- ❑ I have no pain at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – PERSONAL CARE (washing, dressing etc.)
- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self care.
- ❑ I do not get dressed and I wash with difficulty and stay in bed.

Section 3 – LIFTING
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – READING
- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with slight pain in my neck.
- ❑ I can read as much as I want to with moderate pain in my neck.
- ❑ I can not read as much as I want because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

Section 5 – HEADACHES
- ❑ I have no headaches at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

Section 6 – CONCENTRATION
- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

Section 7 – WORK
- ❑ I can do as much work as I want to.
- ❑ I can only do as my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Section 8 – DRIVING
- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I can not drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I cannot drive my car at all.

Section 9 – SLEEPING
- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3 – 5 hours sleepless).
- ❑ My sleep is completely disturbed (5 – 7 hours sleepless).

Section 10 – RECREATION
- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities with some pain in my neck.
- ❑ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck.
- ❑ I cannot do any recreation activities at all.

PAIN SCALE:

Rate the severity of your pain by checking one box on the following scale.

NO PAIN — Excruciating Pain

1	2	3	4	5	6	7	8	9	10

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry)

Patient Name: ______________________ File#: __________ Date: ______________

PLEASE READ THE INSTRUCTIONS:
This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only one box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

Section 1 – PAIN INTENSITY
- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is severe.
- ❑ The pain is severe and does not vary much.

Section 2 – PERSONAL CARE (washing, dressing etc.)
- ❑ I would not have to change my way of washing or dressing in order to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes pain.
- ❑ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increase the pain and I find it necessary to change my way of doing it
- ❑ Because of the pain I am unable to do some washing and dressing without help.
- ❑ Because of the pain I am unable to do any washing and dressing without help.

Section 3 – LIFTING
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights at most.

Section 4 – WALKING
- ❑ I have no pain on walking.
- ❑ I have some pain on walking but it does not increase with distance.
- ❑ I cannot walk more than one km without increasing pain.
- ❑ I cannot walk more than ½ km without increasing pain.
- ❑ I cannot walk more than ¼ km without increasing pain.
- ❑ I cannot walk without increasing pain at all.

Section 5 – SITTING
- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favourite chair as long as I like.
- ❑ Pain prevents me from sitting more than one hour.
- ❑ Pain prevents me from sitting more than half an hour.
- ❑ Pain prevents me from sitting more than ten minutes.
- ❑ I avoid sitting because it increases pain straight away.

Section 6 – STANDING
- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than ½ hour without increasing pain.
- ❑ I cannot stand for longer than ten minutes without increasing pain.
- ❑ I avoid standing because it increases the pain straight away.

Section 7 – SLEEPING
- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Because of pain my normal night's sleep is reduced by less than ¼ of an hour.
- ❑ Because of pain my normal night's sleep is reduced by less than ½ of an hour.
- ❑ Because of pain my normal night's sleep is reduced by less than ¾ of an hour.
- ❑ Pain prevents me from sleeping at all.

Section 8 – SOCIAL LIFE
- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing etc).
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

Section 9 –TRAVELLING
- ❑ I get no pain while travelling.
- ❑ I get some pain while travelling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain while travelling which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain restricts all forms of travel, except that done lying down.

Section 10 – CHANGING DEGREE OF PAIN
- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at present.
- ❑ My pain is neither getting better or worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

PAIN SCALE:
Rate the severity of your pain by checking one box on the following scale.

NO PAIN — Excruciating Pain

1	2	3	4	5	6	7	8	9	10

Beacon Hill Chiropractic and Massage

Payment Authorization Regarding WCB Claims

Please note, on occasion WCB does not authorize claims. It is your responsibility as our patient to pay for your chiropractic treatments.

As well, in the case that a total of three appointments are cancelled or an appointment is missed without 24 hours notice, treatment will be suspended until further review by your WCB Case Worker.

Name: ______________________________

Signed: ______________________________

Date: ______________________________

Witness Name: ____________________ **Witness Signature:** ____________________

WCB Claim Number: ______________________________

MVA / WCB Symptom Checklist

History (Patient/Claimant to Complete)

Patient Name: ______________________________ Date: ______________________________

1. Symptom Checklist

For each symptom, check **YES (if present)** *or* **NO (if not present)**, *and rate severity on a scale of* **0** *to* **10** *where indicated* **0** *is* **"No Pain"** *and* **10** *is* **"Pain as Bad as it Could Be."**

Neck or shoulder pain ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Upper or Mid-back pain ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Low back pain ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Headache ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Arm(s) ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Hand(s) ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Face or Jaw ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Leg(s) ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Foot/Feet ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Pain in Abdomen or Chest ☐ YES ☐ NO

No Pain										Pain as Bad as Could Be
0	1	2	3	4	5	6	7	8	9	10

Feeling of numbness, tingling in arms or hands ☐ YES ☐ NO
Feeling of numbness, tingling in legs or feet ☐ YES ☐ NO
Dizziness or unsteadiness ☐ YES ☐ NO
Vision problems ☐ YES ☐ NO
Hearing problems ☐ YES ☐ NO
Anxiety or worry ☐ YES ☐ NO
Nausea or vomiting ☐ YES ☐ NO
Difficulty swallowing ☐ YES ☐ NO
Problems concentrating ☐ YES ☐ NO

2. Loss of consciousness ☐ YES ☐ NO

3. Have the injuries prevent you from carrying out any of the following:

Explain

- ☐ Daily home activities ____________________
- ☐ Employment ____________________
- ☐ Schooling ____________________
- ☐ Sports or recreation ____________________
- ☐ Other ____________________

4. Do you think your injury will:

- ☐ get better soon
- ☐ get better slowly
- ☐ never get better
- ☐ don't know