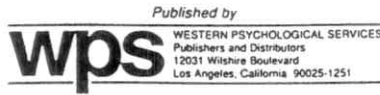


# Philade a Head Injury Questionn (PHIQ)

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**Directions:** The accurate use of this questionnaire is important in establishing the presence of a disabling head injury that may require additional assessment and treatment. Read each question completely and answer as fully as possible. Please be aware that this is only a screening instrument and that it should not be considered diagnostic in nature.

**NOTE:** The reliability of the information obtained in this questionnaire may be significantly increased by asking a spouse or a close relative of the injured person to fill out this form.

Person Filling Out This Questionnaire: \_\_\_\_\_

Relationship to Client/Patient: \_\_\_\_\_

## I. Identifying Information

Name of Client/Patient: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_ Length of Occupation: \_\_\_\_\_

Hand Dominance (circle one):      LEFT      RIGHT

## II. Accident Information

A. Date of accident: \_\_\_\_/\_\_\_\_/\_\_\_\_

B. Briefly describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. During or immediately after the accident: (circle one)

1. Did you lose consciousness?.....YES NO  
If YES, for how long?  
\_\_\_\_\_  
\_\_\_\_\_

2. Did your head whip back and forth?.....YES NO

3. Did you strike your head?.....YES NO  
If YES, on what? (Please detail, indicating point of impact on the diagrams provided.)  
\_\_\_\_\_  
\_\_\_\_\_

4. Did you feel dazed, dizzy, or light-headed?.....YES NO

5. Did you go to a doctor or hospital?.....YES NO  
If YES, for what symptoms?  
\_\_\_\_\_  
\_\_\_\_\_

6. Were you admitted to a hospital?.....YES NO  
Name and telephone number of attending physician:  
\_\_\_\_\_  
(\_\_\_\_) \_\_\_\_\_

7. Were you given any of the following?

a. CT scan.....YES NO

b. EEG.....YES NO

c. Skull X-rays.....YES NO

d. Neurologic examination.....YES NO

e. MRI (magnetic resonance imaging).....YES NO

f. Other diagnostic tests.....YES NO

If YES, describe:  
\_\_\_\_\_  
\_\_\_\_\_



LEFT



RIGHT



FRONT



BACK

## III. Persistent Symptoms

Indicate whether you have had any of the following symptoms:

1. Recurrent headaches.....YES NO

If YES, describe: \_\_\_\_\_

What time of day? \_\_\_\_\_

Where on your head? \_\_\_\_\_

What makes them better? \_\_\_\_\_

What makes them worse? \_\_\_\_\_

2. Seizures.....YES NO

If YES, when? \_\_\_\_\_

(continued on reverse)

### III. Persistent Symptoms (contin)

- 3. Dizziness, light-headedness, blackouts (if that apply) ... YES NO
- 4. Numbness and/or tingling ..... YES NO
- 5. Clumsiness (dropping things, knocking things over, weak grasp) ..... YES NO
- 6. Loss of balance ..... YES NO
- 7. Changes in:
  - a. Vision ..... YES NO
  - b. Hearing ..... YES NO
  - c. Taste ..... YES NO
  - d. Smell ..... YES NO

If you answered YES to any part of Item 7, describe:

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- 8. Frequent pain anywhere ..... YES NO
- 9. Ringing in your ears ..... YES NO
- 10. Sensitivity to noise and/or light ..... YES NO

### IV. Cognitive Aspects of Head Injury

- A. Have you noticed changes in the following?
  - 1. Memory
    - a. Recent ..... YES NO
    - b. Remote ..... YES NO
  - 2. Concentration ..... YES NO
  - 3. Understanding what you read ..... YES NO
  - 4. Understanding what is said to you ..... YES NO
  - 5. Following directions ..... YES NO
  - 6. Doing your job ..... YES NO

- B. Were you able to return to work after your accident? ..... YES NO
  - 1. If YES, when did you return to work?
  - 2. If NO, explain:

- C. Does it take you longer to do things? ..... YES NO
- If YES, explain:

- D. Do you have difficulty initiating and/or completing chores at home? ..... YES NO

- E. Do you have difficulty doing arithmetic (balancing a checkbook, paying bills)? ..... YES NO

If you answered YES to any of the above, describe:

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### V. Personality Changes

- Have you noticed or have family/friends commented that you:
- 1. Are more irritable or short-tempered? ..... YES NO
  - 2. Are more easily fatigued? ..... YES NO
  - 3. Are having mood swings? ..... YES NO
  - 4. Are seclusive, staying at home? ..... YES NO
  - 5. Have crying spells? ..... YES NO
  - 6. Are having depressed moods? ..... YES NO
  - 7. Are eating more or less? ..... YES NO
- If YES, circle one: ..... MORE LESS

- 8. Have had changes in your sleep patterns? ..... YES NO
- 9. Are argumentative? ..... YES NO
- 10. Have given up hobbies/interests? ..... YES NO
- 11. Are fearful (have phobias)? ..... YES NO
- 12. Have had flashbacks of the accident? ..... YES NO
- 13. Have had nightmares? ..... YES NO
- 14. Have less interest in sex? ..... YES NO
- 15. Have been less motivated to do things? ..... YES NO

### VI. Pertinent Personal/Medical History

- A. Are you currently taking prescribed medication(s)? ..... YES NO

If YES, please list them: \_\_\_\_\_

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- 4. Heart disease ..... YES NO
- 5. Diabetes ..... YES NO

- C. Have you ever had any of the following?
  - 1. Previous head injury ..... YES NO
  - 2. Family history of neurological disease ..... YES NO
  - 3. History of seizures ..... YES NO
  - 4. Psychological testing ..... YES NO
  - 5. Treatment for any emotional problems ..... YES NO
  - 6. Learning disability ..... YES NO
  - 7. The experience of failing a grade ..... YES NO
  - 8. Substance use disorder ..... YES NO

- B. Do you now have or have you ever been diagnosed as having any of the following?
  - 1. Hypertension ..... YES NO
  - 2. Migraine headaches ..... YES NO
  - 3. Stroke ..... YES NO

### VII. Comments and/or Additional Information

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