Referring Doctor EEG/ERP Injury Questionnaire

Date: _____

Patient Name: _____ Study Number: _____

DOB: _____

Note: By completing this form, I understand that any unchecked box below is an indication of absence of that condition.

Brief description of the injury: (include if driver, how accident happened, body parts struck, did head strike headrest/window? Was it a rear-end/front-end collision? Speed of collision, etc.)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Date of Injury: _____

At the time of the Accident/Injury:

- ☐ There was loss of consciousness for
  _____ minutes _____ seconds
- ☐ There was NO loss of consciousness
- ☐ Loss of consciousness was witnessed
- ☐ Loss of consciousness was NOT witnessed

Amnesia:

- ☐ The patient demonstrated symptoms of amnesia following the injury
- ☐ The patient did NOT demonstrate symptoms of amnesia following the injury

Amnesia: Amnesia is defined as the failure to form new memories. Determine whether amnesia has occurred and attempt to determine length of time of memory dysfunction – before (retrograde) and after (anterograde) injury. Even seconds to minutes of memory loss can be predictive of outcome. Recent research has indicated that amnesia may be up to 4-10 times more predictive of symptoms and cognitive deficits following concussion than is LOC (less than 1 minute).[1]

Were any medications/drugs/stimulants taken in the 12 hours before study?

- ☐ Alcohol:
- ☐ Caffeine (Coffee, Tea, Cola, Chocolate):
- ☐ Energy Drinks
- ☐ Recreational drugs:
- ☐ Medications: If Yes, what:
- ☐ None

Post Injury Symptoms:

- ☐ Headaches
- ☐ Neck Pain
- ☐ Cognitive impairment
- ☐ Memory impairment
- ☐ Seizure
- ☐ Sleep disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Other:
- ☐ None

Previous History of:

- ☐ Head Trauma Date of Onset: _____
- ☐ Concussion Date of Onset: _____
- ☐ Headaches Date of Onset: _____
- ☐ Cognitive impairment Date of Onset: _____
- ☐ Memory Impairment Date of Onset: _____
- ☐ Dementia/Alzheimer's Date of Onset: _____
- ☐ Anxiety Date of Onset: _____
- ☐ Depression Date of Onset: _____
- ☐ Other psychiatric disorders Date of Onset: _____
- ☐ Sleep disorder Date of Onset: _____
- ☐ Stroke Date of Onset: _____
- ☐ Multiple Sclerosis Date of Onset: _____
- ☐ Seizure Date of Onset: _____
- ☐ ADHD Date of Onset: _____
- ☐ Learning disability Date of Onset: _____
- ☐ Other developmental disorders Date of Onset: _____
- ☐ Recreational drug use Date of Onset: _____
- ☐ Other: _____ Date of Onset: _____ ☐
- ☐ None

Cranial Nerve Testing Results:

- ☐ Cranial Nerve 1 (Olfactory) Abnormality
- ☐ Cranial Nerve 4 (Trochlear) Abnormality
- ☐ Cranial Nerve 5 (Trigeminal) Abnormality
- ☐ Cranial Nerve 8 (Vestibulocochlear) Abnormality
- ☐ Other Cranial Nerve
- ☐ No Cranial Nerve Abnormalities found
- ☐ Did not perform

Are there any Focal Neurological Symptoms (Weakness, Loss of Sensation, Impaired Coordination, Gait Impairment)

☐ Yes ☐ No

If motor vehicle accident, did the patient's air bag deploy?

- ☐ Front air bag
- ☐ Side air bag
- ☐ None
- ☐ Unknown

☐ I understand that any unchecked box above is an indication of absence of that condition.

_____

Referring Physician's Name