Referring Doctor EEG/ERP Injury Questionnaire

Date: February 2, 2019

Patient Name: John Doe **Study Number:** 0000

DOB: 07/21/1986

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

Date of Injury: 01/02/2019

Brief description of the injury: (include if driver, how accident happened, body parts struck, etc.?) **Mr. Doe was a driver of a vehicle involved in an auto vs auto collision. Patient was stopped at a stop sign when he was rear-ended by a large SUV. Approximate speed of SUV was 40 mph. Patient did not hear any sounds of screeching tires. Force was great enough to push Mr. Doe's car into the middle of the intersection. Patient's head hit the steering wheel, and also hit the head rest. Patient remembers feeling very disoriented immediately after the accident. Patient was taken via ambulance to the ER.**

Injuries Sustained includes

- ☐ Patient sustained a direct injury to the head
- ☒ Patient sustained a whiplash injury

At the time of the Accident/Injury:

- ☒ There was loss of consciousness for
  - **2** minutes ☐ Unknown duration of time
  - Loss of Consciousness was witnessed ☐ Yes ☒ No
- ☐ There was NO loss of consciousness

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:
- [x] None

Post Injury Symptoms:

- [x] Headaches
- [x] Neck Pain
- [x] Cognitive impairment
- [x] Memory impairment
- [ ] Seizure
- [ ] Sleep disorder
- [ ] Anxiety
- [ ] Depression
- [x] Other: **tingling in arms**

Previous History of: *Prior to the Injury/accident*

- [ ] 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:
- [x] Anxiety — Date of Onset: **2010 to 2012**
- [ ] Depression — Date of Onset:
- [ ] Other psychiatric disorders — Date of Onset:
- [x] Sleep disorder — Date of Onset: **2010 to 2012**
- [ ] 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:

Cranial Nerve Testing Results:

- [x] Cranial Nerve 1 (Olfactory) Abnormality
- [ ] Cranial Nerve 4 (Trochlear) Abnormality
- [ ] Cranial Nerve 5 (Trigeminal) Abnormality
- [x] 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

Explain: **Weakness of upper extremities, unstable gait**

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.

John Smith, DC
Referring Physician's Name