HEAD INJURY ADDENDUM

Patient Identification

Did the suspect hit you in the head with a part of his/her body, an object, a surface, or something else at any time during the assault? ☐ **NO**, skip this page ☐ **YES**, fill this page out

What did the suspect use to hit your head (e.g., body parts, objects, surface, something else)?

Approximately how many times did the suspect hit you in the head?

LOSS OF AWARENESS SYMPTOMS ASSOCIATED WITH HEAD TRAUMA

Did you lose consciousness?	☐ No	☐ Yes
Are there any gaps in your memory **before** the hit(s) to your head?	☐ No	☐ Yes
Are there any gaps in your memory **after** the hit(s) to your head?	☐ No	☐ Yes
Did your position change during the hits to your head (e.g., standing to laying)?	☐ No	☐ Yes
If yes, do you remember?	☐ No	☐ Yes

HEAD SYMPTOMS EXPERIENCED **AFTER** THE HEAD TRAUMA (indicate if present at time of exam)

Pain to the head (e.g., scalp, face)?	☐ No	☐ Yes	☐ At time of exam
Pain with eye movements?	☐ No	☐ Yes	☐ At time of exam
Pain to the nose?	☐ No	☐ Yes	☐ At time of exam
Pain to the lip/mouth/tongue?	☐ No	☐ Yes	☐ At time of exam
Pain with jaw opening/closing?	☐ No	☐ Yes	☐ At time of exam
Bruising to the head/face?	☐ No	☐ Yes	☐ At time of exam
Swelling to the head/face?	☐ No	☐ Yes	☐ At time of exam
Deviated nose?	☐ No	☐ Yes	☐ At time of exam
Nose bleeding?	☐ No	☐ Yes	☐ At time of exam
Lip/mouth/tongue bleeding?	☐ No	☐ Yes	☐ At time of exam
Tooth pain?	☐ No	☐ Yes	☐ At time of exam
Chipped or loose teeth?	☐ No	☐ Yes	☐ At time of exam
Difficulty breathing (through nose of mouth)?	☐ No	☐ Yes	☐ At time of exam
Other?	☐ No	☐ Yes	☐ At time of exam

NEUROLOGICAL (NEURO) SYMPTOMS EXPERIENCED **AFTER** THE HEAD TRAUMA (indicate if present at time of exam)

Problems with memory, recall, concentration? If yes, give examples. Examples: _____	☐ No	☐ Yes	☐ At time of exam
Vision changes or problems?	☐ No	☐ Yes	☐ At time of exam
Photosensitivity?	☐ No	☐ Yes	☐ At time of exam
Hearing changes or problems?	☐ No	☐ Yes	☐ At time of exam
Dizziness or dizzy spells?	☐ No	☐ Yes	☐ At time of exam
Feeling faint?	☐ No	☐ Yes	☐ At time of exam
Lightheaded?	☐ No	☐ Yes	☐ At time of exam
Confusion?	☐ No	☐ Yes	☐ At time of exam
Disoriented?	☐ No	☐ Yes	☐ At time of exam
Headache?	☐ No	☐ Yes	☐ At time of exam
Numbness or tingling?	☐ No	☐ Yes	☐ At time of exam
Fatigue or sleepiness?	☐ No	☐ Yes	☐ At time of exam
Other?	☐ No	☐ Yes	☐ At time of exam

TOTAL # OF INJURIES INFLICTED BY THE SUSPECT

Total # of head injuries?

Total # of head injuries with **neuro** symptoms?

SUPPLEMENTAL HISTORY SECTION

_____

_____

_____

_____

_____

_____