Patient assessment questionnaire
Head Injury

Auckland Neurosurgical Clinic Ltd

Name:	Sex: Male / Female
Address:	E-mail Address:
	Date of Birth:
Telephone number: (day)	(evening)
GP Name & Address:	
Insurers name and address:	Postcode:
ACC Case Manager & Address:	
ACC Number:	
Occupation:	

(Please circle)

1.	Date & time of Injury			
2.	Did you lose consciousness			
3.	Do you have headache?		Yes	No
4.	What is your concentration like?	good	average	poor
5.	What is your memory like?	good	average	poor
6.	Do you have any fluid running from your nose?		Yes	No
7.	Do you suffer from nausea and vomiting?		Yes	No
8.	Do you have neck pain?		Yes	No
9.	Do you have numbness in arms or legs?		Yes	No
10.	Do you have weakness of the arms or legs?		Yes	No
11.	Have you ever had a seizure?		Yes	No
12.	If you answered yes to question 8, when was your last seizure?			
13.	Have you been incontinent of urine?		Yes	No
14.	Have you had any surgery in the past?		Yes	No
15.	What operation/s was/were performed?			
16.	Date and place of surgery:			
17.	Have you had any illnesses in the past?		Yes	No

If yes please list-

Current Medication:

Aspirin	Yes	No	Plavix (Clopidogrel)	Yes	No
Warfarin	Yes	No			