Health History Form for Brain/Head Injury (Ages 0-4)

Educator Resource 4

Today's Date: _____Child's Name: _____Child's Date of Birth: _____

Person completing this report: _____Relationship to child: _____

Accidents: Has your child ever been in a car accident, experienced a near drowning or suffocation, stopped breathing for one minute or longer or sustained a blow to the head? Yes ____ No____

Falls: Has your child ever fallen from a height greater than 18 inches (i.e., fallen down stairs, rolled off a changing table, fallen from playground equipment, fallen while climbing or fallen when riding a tricycle/bike/scooter) resulting in a fall or fallen onto an object that resulted in a blow to the head? Yes ____ No____

Emergency Room: Has your child ever visited a doctor's office or emergency room because of a loss of consciousness or hit on the head? Yes____ No____

Symptoms or Sickness: Has your child ever had a seizure or loss of consciousness? Yes ____ No ____

If **yes** to any of the above, describe when and what happened: (Include how it occurred and how hard was the hit to the head?)

Changes: Check any changes you noted in the child following the incident described.

Check all that apply	# of Minutes	# of Hours	# of Days	# of Weeks	Or Longer
Decreased strength					
Decreased sucking/swallowing					
Decreased smiling/vocalizing					
Decreased tolerance to light					
Frequent rubbing of eyes					
Extreme irritability/Increased crying					
Swelling of the Soft Spot					
Appears dazed or confused					
Lost consciousness					
Decreased coordination or poor balance					
Decreased ability to lift or hold head					
Decreased language/communication					
Decreased appetite					
Decreased ability to focus eyes					
Unequal pupil size of eyes					
Sleep Changes					
Acts as if head hurts (headache)					
Vomiting					
Sick to stomach					