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

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 fall or fall 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 above.
Check all that apply:

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

Estimate of duration of any of the above signs/symptoms:

Number of Minutes ____, Hours ____, Days ____, Weeks ____, Longer ____

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