Accent Eye Care
and Sports Vision Therapy

Stroke / Head Trauma Symptoms Checklist

Patient: _____ Date: _____ Injury Date: _____

After an injury, people experience a wide range of symptoms. Please rate yourself on each of the following characteristics. Doing so will help your doctor to better understand your injuries and to provide you with appropriate care.

INSTRUCTIONS: Indicate your present symptoms compared to how you felt before your injury. Use the following scale:
"Since the accident, I'm..."

0 – About the same – no problem
1 – A little different – a bit of problem
2 – Moderately different – causes some problems
3 – Very different – a serious problem

SENSORY CHANGES

____ Vision difficulty/Blurred vision
____ Hearing difficulty
____ Dizzy/Vertigo/Ringing in ear
____ Eye fatigue/Strain
____ Numbness/Tingling
____ Noise/Light sensitivity
____ Other - Specify:

GENERAL FUNCTION CHANGES

____ Wake unrested
____ Headache
____ Sleep disturbance
____ No energy/Fatigue/Tire easily
____ "Getting along" with people
____ Sweating/Shortness of breath
____ Loss of interest in food/sex
____ Loss of interest in activities
____ Other - Specify:

COGNITIVE CHANGES

____ Concentration
____ Memory
____ Finding the "right words"
____ Lose "train of thought"
____ Attention
____ Organizing plans or thoughts
____ Disorientation/Confusion
____ Slow thinking
____ Information processing
____ Shortened attention span
____ Distractibility
____ Mental fatigue
____ Other - Specify:

PSYCHOSOCIAL DYSFUNCTION

____ Confrontational attitude
____ Impatience
____ Explosive temper
____ Thoughtlessness
____ Ill-naturedness
____ Other - Specify:

AFFECTIVE CHANGES

____ Not self-confident
____ Apprehensive/Fearful/Worrisome
____ Nervous/Anxious/Tense
____ Depression/Sad/Withdrawn
____ Feel "out of control"
____ Impulsive/Impatient/Irritable
____ Agitation
____ Apathy
____ Frustration
____ Anger
____ Guilt/Self-blame
____ Fear of going crazy
____ Other - Specify:

---------- *If you experience dizziness or vertigo, complete the next page.* ----------

Dizziness and Vertigo Checklist

INSTRUCTIONS: Check the most appropriate column for each question.

	Never	Sometimes	Frequently
1. Do you experience an illusion of false motion? Examples: "The room is spinning; Things are whirling; I am reeling; Everything is swaying; Things are pitching; It looks like things are rocking."			
2. Do you experience nausea, vomiting, pallor and perspiration during these attacks?			
3. Do you experience dizziness while working on computers?			
a. Does this discomfort lead to headaches?			
b. Do words move around on the page?			
4. Do you experience any dizziness:			
a. When in store aisles or malls?			
b. In crowds?			
c. In large open spaces?			
d. In moving vehicles?			
5. Do you experience dizziness with repetitious visual patterns? (examples: floor tile, carpeting in movie theatres, wall paper patterns, etc.)			
6. Do you note an increase in light sensitivity? (particularly to fluorescent lighting)			
7. Do you note difficulties with movement on a television screen?			

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