Patient's Name: _____ Today's Date: _____

Treating Doctor: _____ Date of Injury: _____

Documenting Your Airbag Deployment Injuries

According to the history you have provided us, your recent motor vehicle collision caused your airbag supplemental restraint system to deploy. Because of the potential for serious injuries resulting from such an accident, it is important that you complete the following form to the best of your recollection. Thank you for your assistance.

A. Within moments after the time of impact, did you: ***(circle all that apply)***

1. Black-out (lose consciousness)? If so, for approximately how long were you unconscious? _____
2. Become signficantly disoriented? If so, for approximately how long were you disoriented? _____
3. Experience any nose bleeds, cuts, abrasions, bruises or burns? If so, please detail: _____
4. Have double-vision and/or blurred vision? If so, for how long? _____
5. Experience hearing loss or ringing in the ears? If so, for how long? _____
6. Experience jaw pain, facial numbness/tingling? If so, for how long? _____

Comments: _____

_____

B. At any point *after* the impact, did you experience any of the following symptoms? (*circle all that apply)*

Suspected Mild Brain Trauma

1. Nausea
2. Vertigo/dizziness/lightheadedness
3. Neck pain/stiffness
4. Headache
5. Photophobia (sensitivity to light)
6. Phonophobia (sensitivity to loud noises)
7. Tinnitus (ringing in the ears)
8. Impaired memory
9. Difficulty concentrating
10. Impaired comprehension or awareness
11. Prolonged, unexplained staring
12. A feeling of having a "brain fog"
13. Forgetfulness
14. Impaired logical thinking
15. Difficulty with new or abstract concepts
16. Insomnia (difficulty sleeping)
17. Fatigue
18. Apathy
19. Outburst of anger
20. Mood swings
21. Depression
22. Loss of libido (sex drive)
23. Personality change
24. Intolerance to alcohol

Suspected TMD

25. Clicking in the jaw
26. Popping in the jaw
27. Locking of the jaw
28. Side shift of the jaw upon maximum opening
29. Inability to open the mouth wide
30. Pain on chewing
31. Facial pain
32. Grinding your teeth
33. Jaw muscles sore upon waking
34. Chewing on one side of your mouth
35. Painful teeth
36. Loose teeth
37. Very tender muscles in the front of the neck

Misc.

38. Pain on swallowing
39. Difficulty swallowing
40. Intolerance to strong odors
41. Decreased ability to smell things
42. Decreased ability to taste foods/drinks
43. Vision changes

Comments:

_____

_____

_____

C. If any of the above symptoms were present before the motor vehicle collision, please list them below and identify their intensity and duration:

_____

_____

_____

D. Advise the doctor of any changes in your condition, especially if any of the above symptoms develop *after* completing this form. Please sign below.

Patient's Signature: _____