Philade a Head Injury Questionn (PHIQ)

Lucille M. Curry, Ph.D., Richard G. Ivins, Ph.D.,
and Thomas L. Gowen, J.D.

Published by
WPS WESTERN PSYCHOLOGICAL SERVICES
Publishers and Distributors
12031 Wilshire Boulevard
Los Angeles, California 90025-1251

Directions: The accurate use of this questionnaire is important in establishing the presence of a disabling head injury that may require additional assessment and treatment. Read each question completely and answer as fully as possible. Please be aware that this is only a screening instrument and that it should not be considered diagnostic in nature.

NOTE: The reliability of the information obtained in this questionnaire may be significantly increased by asking a spouse or a close relative of the injured person to fill out this form.

Person Filling Out This Questionnaire: _____

Relationship to Client/Patient: _____

I. Identifying Information

Name of Client/Patient: _____ Date: ___/___/___

Address: _____

Telephone: Home: (_____) _____ Work: (_____) _____ Age: _____ Date of Birth: ___/___/___

Education: _____ Occupation: _____ Length of Occupation: _____

Hand Dominance (circle one): LEFT RIGHT

II. Accident Information

A. Date of accident: ___/___/___

B. Briefly describe the accident: _____

_____

_____

C. During or immediately after the accident: (circle one)

1. Did you lose consciousness? ..... YES NO
   If YES, for how long?

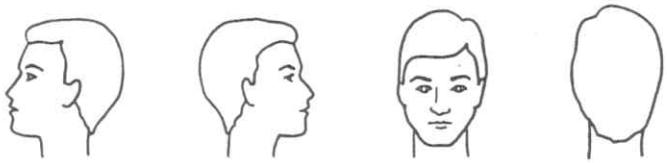
   _____

   _____

2. Did your head whip back and forth? ..... YES NO
3. Did you strike your head? ..... YES NO
   If YES, on what? (Please detail, indicating point of impact on the diagrams provided.)

   _____

   _____



LEFT RIGHT FRONT BACK

4. Did you feel dazed, dizzy, or light-headed? ..... YES NO
5. Did you go to a doctor or hospital? ..... YES NO
   If YES, for what symptoms?

   _____

   _____

6. Were you admitted to a hospital? ..... YES NO
   Name and telephone number of attending physician:

   _____

   (_____) _____

7. Were you given any of the following?
   a. CT scan ..... YES NO
   b. EEG ..... YES NO
   c. Skull X-rays ..... YES NO
   d. Neurologic examination ..... YES NO
   e. MRI (magnetic resonance imaging) ..... YES NO
   f. Other diagnostic tests ..... YES NO
      If YES, describe:

      _____

III. Persistent Symptoms

Indicate whether you have had any of the following symptoms:

1. Recurrent headaches ..... YES NO
   If YES, describe: _____
   What time of day? _____
   Where on your head? _____
   What makes them better? _____
   What makes them worse? _____
2. Seizures ..... YES NO
   If YES, when? _____

   _____

(continued on reverse)

III. Persistent Symptoms (continu

3. Dizziness, light-headedness, blackouts (c... all that apply) ...YES NO
4. Numbness and/or tingling .....YES NO
5. Clumsiness (dropping things, knocking things over, weak grasp) .....YES NO
6. Loss of balance .....YES NO
7. Changes in:
   a. Vision .....YES NO
   b. Hearing .....YES NO
   c. Taste .....YES NO
   d. Smell .....YES NO

If you answe...d YES to any part of Item 7, describe:

_____

_____

_____

_____

8. Frequent pain anywhere .....YES NO
9. Ringing in your ears.....YES NO
10. Sensitivity to noise and/or light .....YES NO

IV. Cognitive Aspects of Head Injury

A. Have you noticed changes in the following?
   1. Memory
      a. Recent .....YES NO
      b. Remote .....YES NO
   2. Concentration.....YES NO
   3. Understanding what you read .....YES NO
   4. Understanding what is said to you .....YES NO
   5. Following directions .....YES NO
   6. Doing your job .....YES NO

   If you answered YES to any of the above, describe:

   _____

   _____

   _____

B. Were you able to return to work after your accident? .....YES NO
   1. If YES, when did you return to work?
   2. If NO, explain:

   _____

   _____

C. Does it take you longer to do things? .....YES NO
   If YES, explain:

   _____

   _____

D. Do you have difficulty initiating and/or completing chores at home?.....YES NO

E. Do you have difficulty doing arithmetic (balancing a checkbook, paying bills)? .....YES NO

V. Personality Changes

Have you noticed or have family/friends commented that you:

1. Are more irritable or short-tempered? .....YES NO
2. Are more easily fatigued? .....YES NO
3. Are having mood swings? .....YES NO
4. Are seclusive, staying at home?.....YES NO
5. Have crying spells? .....YES NO
6. Are having depressed moods? .....YES NO
7. Are eating more or less? .....YES NO
   If YES, circle one: .....MORE LESS
8. Have had changes in your sleep patterns? .....YES NO
9. Are argumentative? .....YES NO
10. Have given up hobbies/interests? .....YES NO
11. Are fearful (have phobias)?.....YES NO
12. Have had flashbacks of the accident? .....YES NO
13. Have had nightmares? .....YES NO
14. Have less interest in sex? .....YES NO
15. Have been less motivated to do things? .....YES NO

VI. Pertinent Personal/Medical History

A. Are you currently taking prescribed medication(s)? .....YES NO

   If YES, please list them:_____

   _____

   _____

   _____

B. Do you now have or have you ever been diagnosed as having any of the following?
   1. Hypertension .....YES NO
   2. Migraine headaches .....YES NO
   3. Stroke .....YES NO
   4. Heart disease .....YES NO
   5. Diabetes .....YES NO

C. Have you ever had any of the following?
   1. Previous head injury .....YES NO
   2. Family history of neurological disease .....YES NO
   3. History of seizures.....YES NO
   4. Psychological testing .....YES NO
   5. Treatment for any emotional problems .....YES NO
   6. Learning disability .....YES NO
   7. The experience of failing a grade .....YES NO
   8. Substance use disorder .....YES NO

VII. Comments and/or Additional Information

_____

_____

_____

_____