

Metcalfes

Solicitors

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FORM FOR USE BY INJURED PARTY

Ref: KM/LG/

Name of Injured Party:-

Date of Incident:

PLEASE CAN YOU TICK IF ANY OF THE FOLLOWING SYMPTOMS HAVE BEEN EXPERIENCED OR ARE STILL BEING EXPERIENCED

	Experienced immediately after incident (state for how long)	Experienced for a number of weeks after the incident (state how many)	Still suffering
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Experienced immediately after incident (state for how long)	Experienced for a number of weeks after the incident (state how many)	Still suffering
Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual lethargy or hyperaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disturbance or problems with hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties in understanding and using language (e.g. problems finding the right word or following conversations)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties judging distance, size and shape (e.g. persistent bumping into furniture, doorways etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with planning, organisation and monitoring of activities compared to pre- incident ability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Experienced immediately after incident (state for how long)	Experienced for a number of weeks after the incident (state how many)	Still suffering
Changes in attention and concentration (e.g. being unable to maintain attention to a particular task or being unable to attend to more than one thing at a time compared to pre-incident)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties coping with crowds or excessive noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disturbance of sense of smell or taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in mood/temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Experienced immediately after incident
(state for how long)

Experienced for a number of weeks after the
incident (state how many)

Still suffering

Changes in sleep pattern

Slurred speech

Depression or anxiety

Signed

.....

Dated

.....

Print Name

Address

.....

Post Code