

Metcalfes

———— Solicitors ————

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FORM FOR FRIEND/RELATIVE OF INJURED PARTY

Ref: KM/LG/

Injured Party Name:-

Date of Incident:

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

	Noted immediately after incident (state when observed)	Noted a number of weeks after the incident (state when)	Still observed
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"/>
Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Noted immediately after incident (state when observed)	Noted a number of weeks after the incident (state when)	Still observed
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"/>

	Noted immediately after incident (state when observed)	Noted a number of weeks after the incident (state when)	Still observed
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"/>

Noted immediately after incident
(state when observed)

Noted a number of weeks after the incident
(state when)

Still observed

Changes in sleep pattern

Slurred speech

Depression or anxiety

General Comments

Signed

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Dated

.....

Print Name

Address

.....

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Post Code