Head Injury Symptoms Questionnaire

Return To ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6

Fax 1-877-686-4222

CLAIM NUMBER	EMPLOYEE NAME	EMPLOYEE NUMBER

CHILD'S NAME

Did your child experience any of the following symptoms after his motor vehicle accident?

Symptom	Describe frequency, severity and how long symptoms lasted
Loss of consciousness	
Amnesia	
Headaches	
Dizziness	
Blurred vision	
Excessive fatigue	
Memory problems	
Concentration problems	
Judgment problems	
Social relationship problems	
Behavioural problems	
Academic performance problems	

Do you wish to add any further comments? (attach a second page if required)

SIGNATURE

DATE