**Concussion Evaluation Request**

**Date:**

**Client Name:**

**DOB:**

**DOI:**

**To: Dr.**

**Brief description of the injury:** (include if driver, how accident happened, body parts struck, etc.?)

**Due to the mechanism of injury and the fact that my client may be exhibiting the following symptoms I am requesting an evaluation for concussion.**

**Post Injury Symptoms:**

Headaches  Neck Pain  Cognitive impairment

Memory impairment  Seizure  Sleep disorder

Anxiety  Depression

Other:

**Previous History of:**

Head Trauma

Concussion

Headaches

Cognitive impairment

Memory Impairment

Anxiety

Depression

**If motor vehicle accident, did the client's air bag(s) deploy?**

Front air bag

Side air bag

None

Unknown

I understand that any unchecked box above is an indication of absence of that condition.

Requesting Attorney