Concussion / Head Injury Questionnaire

Title | Surname

Given name(s)

Date of birth / /

1 What was the date of the incident?

2 How did the injury occur?

3 Were you rendered unconscious?

No ☐ ***Go to next question***

Yes ☐

For how long?

4 Did you have a skull x-ray or any other investigation?

No ☐

Yes ☐

5 Since the accident, have you had:

☐ Headaches or dizziness?

☐ Any episodes of momentary loss of sight or blackout?

☐ Fits?

☐ Paralysis or weakness of any part of the body?

6 Please advise the names and addresses of doctors consulted

Name

Address

State | Postcode

Date first consulted / /

Date last consulted / /

Question 6 continued …

Name

Address

State | Postcode

Date first consulted / /

Date last consulted / /

7 Did you require any time off work?

No ☐ ***Go to Declaration***

Yes ☐

Please advise details

Dates / / / /

DECLARATION

The answers to the questions above are true and complete and this supplementary questionnaire forms part of my application for insurance.

Signature

X ..... Date / /

Please return this completed form to:

Smartsave
PO Box 1282
Albury
NSW 2640