Concussion Patient Self-Assessment: NEW

Name:_____ Date:_____

Age: _____ Date of Birth: _____ Gender: Male/Female

Who referred you to this office?: _____

Height: _____ Weight: _____ Handedness: Right/Left/Ambidextrous

Native Country: _____ Primary Language: _____

Secondary Language(if fluent): _____

Details of Current Injury

Date of Injury:_____ Sport: _____ Position: _____

How did the injury occur?: Head-head contact Head-body part contact Head-object contact

Please describe how the injury occurred and what happened immediately after:

_____
_____
_____
_____

Did patient lose consciousness? Yes No If yes, how long was the patient unconscious? _____

Was a sideline evaluation performed? Yes No

If yes, who performed the sideline evaluation? _____

Did the patient continue to participate in the athletic activity after the injury: Yes No

Has the patient been evaluated by a medical professional since the injury?: Yes No

If yes, where/by whom?: _____

If yes, were neuroimaging (brain CT or MRI) performed?: Yes No

If yes, when/where were neuroimaging performed?? _____

Do symptoms worsen with mental activity? Yes No

If yes, what activities increase symptoms? _____

Name: _____

Since the injury has the patient engaged in:		
Strenuous exercise?	Yes/No	If yes, what activity? If yes, did symptoms worsen/recur? Yes/No
School attendance?	Yes/No	If yes, what date did patient return to school?: _____ If yes, is patient attending: Full days? Partial days? Describe current attendance and related issues:
Homework?	Yes/No	If yes, is patient completing regular coursework or modified work load? Describe current workload? If yes, do symptoms worsen/recur during activity? Yes/No
Video games?	Yes/No	If yes, do symptoms worsen/recur during use? Yes/No
Computer use (>5min/day)?	Yes/No	If yes, do symptoms worsen/recur during use? Yes/No
Smart phone use (>5min/day)?	Yes/No	If yes, do symptoms worsen/recur during use? Yes/No
Tablet/iPad use (>5min/day)?	Yes/No	If yes, do symptoms worsen/recur during use? Yes/No

Concussion History	
	# of previously diagnosed concussions (excluding current injury)
	# of concussions resulting in confusion
	# of concussions that resulted in memory loss for events that occurred immediately AFTER injury
	# of concussions that resulted in memory loss for events that occurred immediately BEFORE injury
	# of "dings" previously experienced during or after sport play
	Total amount of time (days/weeks/months) held out from sports

Previous Concussions (Please list all previous concussions)		
How did the previous concussion(s) occur?	Date	Recovery Time (Days/Months)

Name: _____

Academic History	
School Name:	Current Grade:
Academic Performance: Above average Average Below Average	
Have you ever needed to repeat one or more years of school? Yes No	
Have you ever attended special education classes? Yes No	

Athletic History	
Current Sport(s):	Current Position(s):
Level of participation (circle): High school Club Recreational	

Concussion-Related Medical History			
Current Medications:			
Have you ever been diagnosed with:		Have you ever been treated for:	
Autism	Yes No	Chronic Headaches	Yes No
ADD/ADHD	Yes No	Migraine Headaches	Yes No
Learning disability	Yes No	Epilepsy/Seizures	Yes No
Anxiety	Yes No	Meningitis	Yes No
Depression	Yes No	Brain Surgery	Yes No
Bipolar disorder	Yes No	Substance Abuse	Yes No
Other Psychiatric Disorder	Yes No	Psychiatric Condition	Yes No
Sleep Problem	Yes No		
Seizure Disorder	Yes No	Are you prone to motion sickness?	Yes No
Other Medical Problem:	Yes No	Have you ever had speech therapy?	Yes No

Name: _____

Immediate Symptoms (0-48 hours post injury) Please report the symptoms experienced by the patient during the first 48 hours after injury. Circle appropriate severity/timing.			
Symptom	Severity	Timing	Description
Memory loss: For events that occurred immediately BEFORE or AFTER injury	None/Mild/Moderate/Severe	Constant/Intermittent	
Disorientation/Confusion	None/Mild/Moderate/Severe	Constant/Intermittent	
Headache	None/Mild/Moderate/Severe	Constant/Intermittent	Throbbing/pressure/dull Worse AM / PM What makes it worse?
"Pressure in head"	None/Mild/Moderate/Severe	Constant/Intermittent	
Neck Pain	None/Mild/Moderate/Severe	Constant/Intermittent	
Dizziness	None/Mild/Moderate/Severe	Constant/Intermittent	
Nausea	None/Mild/Moderate/Severe	Constant/Intermittent	
Vomiting	Yes/No	How many episodes?_	
Balance problems	None/Mild/Moderate/Severe	Constant/Intermittent	
Seizure activity	Yes/No	How many episodes?_	
Numbness/tingling	None/Mild/Moderate/Severe	Constant/Intermittent	
Change in vision (Difficulty seeing, seeing double, seeing spots or any other changes)	None/Mild/Moderate/Severe	Constant/Intermittent	
Sensitivity to light	None/Mild/Moderate/Severe	Constant/Intermittent	
Hearing changes (Ringing in the ears, difficulty hearing or any other changes)	None/Mild/Moderate/Severe	Constant/Intermittent	
Sensitivity to sound	None/Mild/Moderate/Severe	Constant/Intermittent	
"Don't feel right"	None/Mild/Moderate/Severe	Constant/Intermittent	
Feeling slowed down	None/Mild/Moderate/Severe	Constant/Intermittent	
Feeling "in a fog"/"dinged"	None/Mild/Moderate/Severe	Constant/Intermittent	
Difficulty remembering	None/Mild/Moderate/Severe	Constant/Intermittent	
Difficulty Concentrating	None/Mild/Moderate/Severe	Constant/Intermittent	
Low Energy/Fatigue	None/Mild/Moderate/Severe	Constant/Intermittent	
Sleep changes	None/Mild/Moderate/Severe	Sleeping MORE or LESS than usual?	Taking naps?
More emotional	None/Mild/Moderate/Severe	Constant/Intermittent	
Easily annoyed or moody	None/Mild/Moderate/Severe	Constant/Intermittent	
Sadness	None/Mild/Moderate/Severe	Constant/Intermittent	
Nervousness/anxiety	None/Mild/Moderate/Severe	Constant/Intermittent	
Other:			

Name: _____

CURRENT Symptoms (Symptoms you feel TODAY) Please report the symptoms experienced by the patient today on the day of examination. Circle appropriate severity/timing.			
Symptom	Severity	Timing	Description
Memory loss: For events that occurred immediately BEFORE or AFTER injury	None/Mild/Moderate/Severe	Constant/Intermittent	
Disorientation/Confusion	None/Mild/Moderate/Severe	Constant/Intermittent	
Headache	None/Mild/Moderate/Severe	Constant/Intermittent	Throbbing/pressure/dull Worse AM / PM What makes it worse?
"Pressure in head"	None/Mild/Moderate/Severe	Constant/Intermittent	
Neck Pain	None/Mild/Moderate/Severe	Constant/Intermittent	
Dizziness	None/Mild/Moderate/Severe	Constant/Intermittent	
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Vomiting	Yes/No	How many episodes?_	
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Other:			

Name: _____