Adult Neurology | Pediatric Neurology | Orthopaedics | Physical Medicine & Rehabilitation

Concussion Program New Patient Form

Name:_____ **Referred by:** _____
(Physician, Athletic Trainer, Nurse, Emergency Department, Self)

If this was a sport related concussion, please complete 1-7 below:

1. Sport:_____ **2. School:**_____

3. Athletic Trainer or School Nurse: _____

4. Baseline ImPACT Test? Yes No
(Bring baseline and most recent score to 1st appointment)

5. Average Academic Performance
A+ A B+ B C+ C

6. Athletic Trainer or School Nurse: _____

7. Who do you live with?
☐ One-Parent
☐ Two-Parent
☐ Other (specify who: grandparent, friend, etc _____)

Tell us about your most recent concussion:

1. When did it occur? _____

2. How did it happen? **(sport, fall, assault, MVA)**

_____

_____

3. Circle the symptoms you had at the time of the injury:
Loss of consciousness (how long?_____) Amnesia Confusion Headache Dizziness
Other_____

4. Did you go a hospital or urgent care for your injury? Yes No If yes, when?_____

5. Have you had any of the following imaging tests since your injury?
Head CT Head MRI Neck x-rays Neck CT No Imaging

6. Is there current legal action involved in your concussion? Yes No

7. List the dates you were unable to play your sport due to your injury: **(disregard if not playing sport)**

_____

_____

[Continued on next page]

8. List the dates you were unable to attend school or work due to your injury:

_____

_____

9. Which symptoms or problems have been bothering you the most since your concussion?:

_____

_____

10. What medications or therapies have you used to treat your concussion symptoms?

_____

_____

Prior Concussion History:

Number of previous concussions: _____

Dates of prior concussions: _____

Current Medications ☐ **None**

List all medications you care currently taking including herbs, vitamins, or supplements

Name of Medication	Dosage

Medical History ☐ **None**

List all past and current medical problems (ex: asthma) and surgeries (ex: ACL repair)

Medical Problem	Surgeries

Do you use or have you ever used:

Alcohol	Y	N	Drinks per week _____
Marijuana	Y	N	
Nicotine products/Tobacco	Y	N	

Please circle Personal History (PH), Family History (FH), or None (N)

History of headache(s)	PH	FH	N
History of migraine(s)	PH	FH	N
History of neurodegenerative disease (Alzheimer's, Parkinson's)	PH	FH	N
Anxiety	PH	FH	N
Depression	PH	FH	N
Sleeping Disorder	PH	FH	N

Developmental Delay	PH	FH	N
Sensory Integration Disorder	PH	FH	N
Processing Disorder	PH	FH	N
Dyslexia	PH	FH	N
ADHD / ADD	PH	FH	N
Strabismus	PH	FH	N
Lazy Eye	PH	FH	N
Motion Sensitivity/Car Sickness	PH	FH	N
Brain/Spine Tumor	PH	FH	N
Brain/Spine Infection	PH	FH	N