UNIVERSITY ORTHOPEDICS

CONCUSSION INITIAL VISIT FORM

Demographics

Patient Name: _____ Date of Consultation: _____
DOB: _____ Sex: _____ Age: _____
Who referred you to our clinic? _____
Primary Care Physician: _____
Pharmacy Name/Address: _____
Your E-mail Address: _____ Preferred Phone #: _____
Can we leave a message regarding your care on your voice mail/answering machine? ***Yes*** ***No***

POST CONCUSSION SYMPTOM SCALE

1. The following scale is to assess the symptoms which are due to your concussion. **Please rate only those symptoms which you started experiencing at the time of your concussion AND were still experiencing in the last 24 hours.**

	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck pain	0	1	2	3	4	5	6
Balance problems or dizziness	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Vision problems	0	1	2	3	4	5	6
Hearing problems / ringing	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Feeling "dinged" or "dazed"	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
More emotional than usual	0	1	2	3	4	5	6
Irritable	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or anxious	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Other: _____	0	1	2	3	4	5	6

Sport-Related Concussion Patients

New Injury

In order for us to help you recover from your brain injury it is important to know as much as we can about how you were injured and what problems you've had since your injury. The questions below help doctors treat your concussion.

2. On what day did you sustain your most recent concussion? _____ *(mm/dd/yyyy)*

3. During which sport did you sustain your most recent concussion? _____

4. Which position were you playing at the time? _____

5. On the day you sustained your injury, did you continue to play after the injury? yes no

6. *If yes*, how long did you continue to play for?

(Please circle) 0-1 min. 1-5 min. 5-15 min. 15-30 min. 30-60 min. >60 min.

7. Have you continued to exercise since your injury? yes no

8. Did your injury occur during practice or a game? practice game

9. Did you lose consciousness (get knocked out) at the time of your concussion? yes no

10. I*f yes,* for how long, approximately, were you unconscious?

(Please circle) 0-10 sec. 10-30 sec. 30-60 sec. 1-3 min. 3-5 min. 5-10 min. 10-15 min. >15 min.

11. Have you lost your memory of events which occurred **before** your concussion? yes no

12. *If yes,* how many minutes, approximately, are you unable to remember?

(Please circle) 0-1 min. 1-3 min. 3-5 min. 5-10 min. 10-15 min. >15 min.

13. Have you lost your memory of events which occurred **after** your concussion? yes no

14. *If yes,* how many minutes, approximately, are you unable to remember?

(Please circle) 0-1 min. 1-3 min. 3-5 min. 5-10 min. 10-15 min. >15 min.

15. If you are no longer having symptoms from your concussion, on what day did you last have symptoms?
date: _____ *(dd/mm/yyyy)*

16. Have you been diagnosed with a sport-related concussion **in the past?**

(Please circle) yes no **(If no, please skip to question 24)**

17. How many sport-related concussions have you had **in the past**?

(Please circle) 1 2 3 4 5 6 7 8 9 10 >10

18. During which months/years (approximately) did you sustain your concussion(s)?

(example) June 2005 _____ _____
_____ _____ _____

19. During which sport(s) did you sustain your concussion(s)?

_____ _____ _____

20. Who diagnosed you with your previous concussions? *(Please circle all that apply)*

athletic trainer coach doctor parent school nurse other: _____

21. Who managed your previous concussion(s) including your return to athletics? *(circle all that apply)*

athletic trainer coach doctor parent school nurse other: _____

22. Have you ever had a concussion which was not related to sports *(for example: motor vehicle accident, fall from a height, etc…)?* *(Please circle)* yes no

23. *If yes,* how many?

(Please circle) 1 2 3 4 5 6 7 8 9 10 >10

24. Have you ever sustained a blow to the head which was **NOT** diagnosed as a concussion but was followed by one or more of the signs or symptoms listed in the Post Concussion Symptom Scale? (The Post-Concussion Symptom Scale is on the first page of this questionnaire) *(Please circle)* yes no

25. *If yes,* during which sport(s) did this occur? _____ _____

26. Have you ever had a major injury of the brain other than concussion? *(for example: subdural hemorrhage, subarachnoid hemorrhage, epidural hemorrhage, bleeding into the brain, skull fracture, etc…)*

(Please circle) yes no

27. Do you have any of the following? *(Please circle all that apply)*

attention deficit hyperactivity disorder (ADHD)	attention deficit disorder (ADD)
seizures	a learning disability
complex regional pain syndrome	developmental delay
special education classes	dyslexia

28. Have you ever been diagnosed with meningitis? *(Please circle)* yes no

29. **Before your concussion:**

    a. Did you feel nauseous on an airplane rides or on long car rides? yes no

    b. Were you ever treated by a doctor for headaches? yes no

30. Have you ever been diagnosed with migraine(s) headaches? yes no

31. Has anyone in your family ever been diagnosed with migraines? yes no

32. *If yes,* what is their relation to you? _____

33. Have you been diagnosed with a psychiatric condition? yes no

34. *If yes,* please circle the condition(s)

    depression post-traumatic stress disorder bipolar disorder

    anxiety other: _____

35. Has anyone in your family been diagnosed with a concussion? yes no

36. *If yes,* what is their relation to you? _____

37. Have you ever had computerized neuropsychological testing done *(ImPact, CogSport, Head Minder),* before the start of an athletic season, in case you sustain a concussion?

    (Please circle) yes no

38. If *yes,* please name the school/organization which administered this testing: _____

39. Please include your past medical history including chronic medical conditions (e.g., *asthma, diabetes)*

_____	_____	_____
_____	_____	_____

40. Please list all of the medications you were taking **at the time of your injury**:

_____ _____ _____
_____ _____ _____

41. Please list all of the medications you are **currently** taking:

_____ _____ _____
_____ _____ _____

42. Please list any medications you are allergic to:

_____ _____
_____ _____

Patient Signature: _____ Date: _____

Thank you for completing this intake form.

OFFICE USE ONLY: **PHYSICIAN NOTES:**

WEIGHT: _____

BP: _____/_____

PULSE: _____

MA'S INITIALS: _____

ROOM NUMBER: _____

Physician Signature: _____ Date: _____