EL DORADO HILLS SPORTS MEDICINE

(office use) Medical Record # _____

CONCUSSION HISTORY FORM

Patient name: _____ **Date of Birth:**_____ **Age:**_____

Current Sport/Team/Position:_____

Other sports played:_____

Years of education completed: ____ **Primary language:**_____ **Second language:**_____

Injury Characteristics

1. Date/time of injury:_____ Reporter:___Patient ___Parent ___Spouse ___Other

2. Injury description:_____

_____

2a. Is there evidence of a forcible blow to the head (direct or indirect?) _____Yes _____No

2b. Is there evidence of intracranial injury or skull fracture?_____Yes _____No _____Unknown

2c. Location of impact:

____Frontal ____L Temporal ____L Parietal ____Neck

____Occipital ____R Temporal ____R Parietal ____Indirect Force

3. Amnesia Before (Retrograde): Are there any events just BEFORE the injury that you/athlete has no memory of (even brief)? _____ Yes _____ No If yes, duration? _____

4. Amnesia After (Anterograde): Are there any events just AFTER the injury that you/athlete has no memory of (even brief)? _____ Yes _____ No If yes, duration? _____

5. Loss of consciousness: Did you/athlete lose consciousness? _____ Yes _____ No

If yes, duration? _____

6. Early Signs: ____Appears dazed or stunned ____Is confused about events

____ Answers questions slowly ____Repeats questions

____Forgetful (recent info)

7. Seizures: Were seizures observed? _____ Yes _____ No Details _____

(continued on next page)

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Symptom Checklist

Please rate how much the following symptoms bother you/athlete today, or in the past day:

	None	Mild		Moderate		Severe	
PHYSICAL (10)							
Headache	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Visual problems	0	1	2	3	4	5	6
Fatigue	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
Numbness/Tingling	0	1	2	3	4	5	6
COGNITIVE (4)							
Feeling mentally foggy	0	1	2	3	4	5	6
Feeling slowed down	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
EMOTIONAL (4)							
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Nervousness	0	1	2	3	4	5	6
SLEEP (4)							
Drowsiness	0	1	2	3	4	5	6
Sleeping less than usual	0	1	2	3	4	5	6
Sleeping more than usua	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
TOTALS							
	Total number of symptoms present						
	Total score of symptoms						

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Risk Factors for Protracted Recovery

1. Concussion history? _____Yes _____No

1a. Previous #: 1 2 3 4 5 6+

1b. Longest symptom duration (please indicate approximate length):

Days_____ Weeks_____ Months_____ Years_____

1c. If multiple concussions, did less force cause re-injury? _____Yes _____No

2. Headache history? _____Yes _____No

2a. Prior treatment for headache? _____Yes _____No

If Yes, what treatment(s): _____

2b. History of migraine headache? _____Personal _____Family

3. Developmental history

3a. Learning disability? _____Yes _____No

3b. Attention-Deficit/Hyperactivity disorder? _____Yes _____No

3c. Have you repeated or skipped a grade? _____Yes _____No

If Yes, which one(s): _____

3d. What type of student are you?

_____Above Average _____Average _____Below Average

4. Psychiatric history. Please tell us if you have any of the following:

4a. Anxiety _____Yes _____No

4b. Depression _____Yes _____No

4c. Sleep disorder _____Yes _____No

4d. Other psychiatric disorder _____Yes _____No

4e. What current stressors do you have in your life?

(End of Concussion History Form)