Patient Name: _____

Date of Birth: _____

NEW INJURY VISIT

*** On the chart below, please circle only those symptoms that STARTED when you sustained your concussion, and are STILL bothering you in the last 24 HOURS.***

If you have always had a certain symptom, like trouble paying attention, and it is the same as always, then circle 0. But if it is worse than normal choose 1 to 6.

(Please choose only ONE number for each symptom.)

Somatic Symptoms	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
Nausea or vomiting	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

Vestibular Symptoms	None	Mild		Moderate		Severe	
Balance problems or dizziness	0	1	2	3	4	5	6
Hearing problems / ringing	0	1	2	3	4	5	6
Vision problems	0	1	2	3	4	5	6

Emotional Symptoms	None	Mild		Moderate		Severe	
More emotional than usual	0	1	2	3	4	5	6
Irritable	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

Cognitive Symptoms	None	Mild		Moderate		Severe	
Confusion	0	1	2	3	4	5	6
Feeling like "in a fog"	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
"Don't feel right"	0	1	2	3	4	5	6
Feeling "dinged" or "dazed"	0	1	2	3	4	5	6

Sleep Symptoms	None	Mild		Moderate		Severe	
Feeling slowed down	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
Trouble falling asleep	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6

Total Post-Concussive Symptom Score (PCSS): _____

1. What is the most troublesome symptom that you are still having? _____

2. What are you most concerned about, if anything, regarding your concussion? _____

_____

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

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

Headache Symptoms:

If you are no longer having headaches from your concussion, please skip this section.

a. **How often do your headaches occur?** ***Please circle all that apply***

Constantly **Daily intermittently** **Every other day** **A few days/week** **A few days/month**

Other (please list): _____

b. **Have you used medications to treat this concussion?** ***If yes, please circle all that apply***

Acetaminophen (Tylenol) **Ibuprofen (Advil, Motrin)** **Naproxen (Aleve)**

Prescription medications (ex. Amitriptyline, Elavil, Gabapentin, Neurontin, Topamax, Topirimate)

Other medications:_____

Which medication has worked the best?

_____

c. ***(Circle all that you have tried)*** **Acupuncture** **physical therapy** **massage therapy** **chiropractor**

d. **Other treatments (please list): _____**

e. **What makes your headaches worse?** ***Please circle all that apply***

Movement **Noise** **Light** **School work** **Poor sleep**

TV **Exercise** **Computer** **Reading** **Smartboard at School**

Other (please list): _____

f. **What makes your headache better?** ***Please circle all that apply***

Rest **Medication** **Sleep** **Darkness** **Other: _____**

g. **How would you best describe your headaches?** ***Please circle all that apply***

Pressure **Pounding** **Throbbing** **Sharp** **Aching** **Like a band**

5. On the day you sustained your injury, how long did you continue to play after the injury? *(Please circle)*

I didn't continue to play 5-15 min 30-60 min
1-5 min 15-30 min more than 60 min

6. If you were "knocked out", for how long, approximately, were you unconscious? *(Please circle)*

I didn't get knocked out 10-60 sec More than 5 min
Less than 10 sec 1-5 min

7. Since your injury, have you been doing any exercise? *(Please circle)* Yes No

8. How much school have you missed because of your concussion since your last appointment? *(Please circle)*

None (No school missed) 2-4 days 1-2 weeks More than 1 month
1 day 5-7 days 2-4 weeks

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

Attention deficit disorder (ADD) A learning disability Dyslexia
ADHD Complex regional pain syndrome IEP
Special education classes Developmental delay 504 Plan

10. Have you ever been diagnosed with any of these? *(Please circle all that apply)*

Depression Anxiety Migraines
Bipolar disorder Post-Traumatic Stress Disorder Tension headaches
Other: _____

11. Since your injury, have you had any imaging? *(Please circle all that apply)*

CT Scan MRI X-rays

12. Have you ever had computerized neuropsychological testing done *(ImPACT, CogSport, Head Minder)* **before or after this injury**? *(Please circle)* Yes No

CONCUSSION HISTORY:

How many other concussions have you had **before this injury**? *(Please circle)*

1 2 3 4 5 6 7 8 9 10 >10

During which months/years (approximately) did you get your prior concussion(s)?		**During which activities did you get your prior concussion(s)?**	**How long did the concussion last?** **Please write in one of the following:*	
Month	**Year**		0-7 days 8-14 days 15-30 days 1-3 months	3-6 months 6 months – 1 year > 1 year

MEDICAL/SURGICAL HISTORY

13. Do you have a history of chronic headaches **before** your most recent concussion? If yes, please list the diagnosed type of headache if you know it. (ex: tension, migraine, cluster)

_____

_____

a. How often? (1x/week, 1x/month, etc.)_____

14. Please list any **chronic medical conditions** you have? (ex: seizures, diabetes, heart disease, high blood pressure)

_____

_____

15. Please list the types and dates of any **surgeries** you have had in the past: _____

_____

_____

16. Please list any **family medical problems** (ex: bleeding or clotting problems, sudden cardiac death, rheumatoid arthritis, migraines, thyroid disorders, ADD/ADHD, depression, or other conditions)

_____

_____

17. Do you have now, or have you recently had, any of the following? *(Please circle all that apply)*

Fevers/chills	Abdominal pain	Constipation	Diarrhea
Nausea	Vomiting	Weight changes	Appetite changes
Bladder incontinence	Shortness of breath	Chest pain	Rashes
Seizures	Weakness	Fatigue	Joint swelling
Morning stiffness	Temperature intolerance	Hair loss	Other: _____

10. Please list all **medications** you are currently taking:

_____ _____ _____

_____ _____ _____

11. Please list any medication you are **allergic** to:

_____ _____ _____

MD Sign/Date: _____