

# CONCUSSION INTAKE FORM

## Background

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### INJURY INFORMATION

Date of injury: \_\_\_\_\_ Time of day: \_\_\_\_\_ ED Referral: Yes No

Describe injury: \_\_\_\_\_

Cause of injury:  MVA  Fall  Assault  Sport (If yes, which sport? \_\_\_\_\_)

Other: \_\_\_\_\_

Loss of consciousness: Yes No Length of time: \_\_\_\_\_

### Amnesia:

Before event (do not remember things that happened before event) Yes No Duration: \_\_\_\_\_

After event (do not remember things that happened after event) Yes No Duration: \_\_\_\_\_

Seizure: Yes No Details: \_\_\_\_\_

Initial signs or symptoms following event: \_\_\_\_\_

### PAST HISTORY - BEFORE MOST RECENT CONCUSSION

Previous concussions: Yes No Previous number: 1 2 3 4 5 6+

Date of last concussion: \_\_\_\_\_ How long did it take to recover? \_\_\_\_\_

Have you had previous baseline cognitive testing performed (ImPACT)? Yes No

Where?: \_\_\_\_\_

Have you had any problems with any of the conditions listed below prior to this head injury?

### Check all that apply:

- Learning disability
- Attention deficit disorder (ADD)
- Attention deficit hyperactivity disorder (ADHD)
- Headaches
- Depression
- Anxiety
- Car or motion sickness
- Sleep problems (such as insomnia)
- Eye problems (such as a "lazy eye") as a child

SYMPTOM SCALE

Score yourself on the duration of the following symptoms throughout **the past 24 hours**:

		<b>Briefly</b>		<b>Sometimes</b>		<b>Always</b>	
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/vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Numbness/tingling	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Ringing in ears	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitive to light	0	1	2	3	4	5	6
Sensitive to noise	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
Do not feel right	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
Fatigue/low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Sleeping more	0	1	2	3	4	5	6
Sleeping less	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritable	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous/anxious	0	1	2	3	4	5	6

**TOTAL SCORE:** \_\_\_\_\_