Brief Post-Concussion History

Information requested on this questionnaire is an important part of your child's evaluation and care. We appreciate your taking the time to fill it out fully, and carefully, and the highest standards of professional confidentiality are maintained. When consent to release information is granted, you may choose which information may/may not be released, and revoke that consent at any time.

Today's Date: ________________ Name of Person Completing Form: ____

DEMOGRAPHIC INFORMATION

Client Name:____

School: ____ Grade: _______

School Contact Person: ____ Email: ____

Phone: ___________________________________ School Fax: ___________________________

Athletic Trainer (if applicable): ________________________________Phone: ________________________Email:______________________

Other treating professionals (if applicable, such as psychologist, neurologist, sports medicine, etc):

____Phone:_______________________ Fax: _____________________

____Phone:_______________________ Fax: _____________________

____Phone:_______________________ Fax: _____________________

REFERRAL INFORMATION

Referring Physician: _______________________________________ Phone: _______________________Fax: _______________________

Primary Care Physician: _____________________________________ Phone: _______________________ Fax: ________________________

MEDICAL & DEVELOPMENTAL HISTORY

Dates of previous concussions / brain injuries (use best estimate if unsure) ____

____

Does client have any history of any of the following medical, developmental, or psychiatric issues that may impact the symptoms, duration and impact of a concussion? (**Check here if no history of anything listed below**: □)

	Patient (diagnosed or treated)	Suspected, not diagnosed		Patient (diagnosed or treated)	Suspected, not diagnosed
Headaches (pre-injury)			Speech/Language Difficulties		
Seizures			School Retention		
Anxiety			Tutoring/Special Education		
Depression			Seasonal allergies		
Other mood or behavior disturbance			History of motion sickness		
ADHD / ADD			Diabetes / Hypoglycemia		
Learning Disability			Cutting or other self-harm		
Undiagnosed learning or attention problems			Drug/Alcohol use?		

Any other history of medical conditions, disorder, accidents, hospitalizations or surgeries:

Did client experience any early medical problems or complications during pregnancy/delivery? □ No □ Yes

Please explain:____

Current medications and dosage ____

Pre-injury history of motion sickness? □ No □ Yes Pre-injury history of dizziness when sitting or standing quickly? □ No □ Yes

Vision: Date of last eye exam: ________________ □ Normal History of eye-tracking problems? □ No □ Yes Motion sickness:

□ Glasses or contacts? □ No □ Yes Astigmatism? □ No □ Yes Near-sighted? □ No □ Yes Far-Sighted? □ No □ Yes

Any pre-existing problems with sleep? (e.g., falling or staying asleep, waking up easily) □ no □ yes: _____________________________________

Average amount of sleep on school nights ______ Does this seem to be enough to function well? □ no □ yes ____________________________

Any concerns about patient's emotional functioning? □ Yes □ No Concerns or history of suicidal/homicidal thoughts? □ Yes □ No

FAMILY HISTORY

Anyone in **biological** family with history of □ Mood/behavior disorders □ Headaches / migraines □ Alzheimer's
□ Learning/attention problems □ Sleep disorders □ NONE of those

Names of parents/legal guardians:

Mother/Parent 1 __________________________ Age ____ Education ____________ Occupation _________________________________

Father/Parent 2 __________________________ Age ____ Education _____________ Occupation ________________________________

Was client adopted? □ no □ yes Does client split time in different households? □ no □ yes

List all persons with whom patient lives (in either the same or different households)

Name	Age	Relationship	Name	Age	Relationship

General level of stress in the home, before the injury (Scale 1-10, 1=little, 10-extreme) ____

Describe any ongoing, significant family or other stressors or conflicts in patient's life? □ not applicable

____

ACADEMIC AND SOCIAL HISTORY

Any concerns about grades/school/work? □ Before injury □ Since injury □ NONE/NA Typical grades: □ A's □ B's □ C's □ D's □ F's

Any history of concerns or delays with: □ Early fine motor skills □ Learning to talk / early speech □ School-related learning □ NONE

Any pre-injury history of: tutoring □ no □ yes school accommodations □ no □ yes 504 Plan □ no □ yes IEP □ no □ yes

Counseling or psychotherapy □ no □ yes

Check the box that best represents typical performance on standardized testing:

	Very Superior 98th Percentile +	Superior 91st-97th percentile	High Average 75th-90th percentile	Average 25th-75th percentile	Below Average 9th-25th percentile	Borderline below 9th
Reading:	☐	☐	☐	☐	☐	☐
Math:	☐	☐	☐	☐	☐	☐

Classes - list in order, including lunch □ block schedule □ some AP classes □ some online classes □ not in school

Class / Subject	Teacher	Clinician Notes

Are teachers or other school personnel aware of the injury? □ No □ Yes: have any accommodations been made? □ No □ Yes

If employed, is supervisor or other personnel aware of the injury? □ No □ Yes: have any accommodations been made? □ No □ Yes

Average amount of time spent nightly on: homework: _____ computer/video games ______ watching TV _______

Upcoming exams, papers, projects over next 2-3 weeks (what, when due): ____

____

Upcoming standardized testing:____

Extracurricular activities (what, how often) ____

____

Work (list any current jobs and hours/week): ____

Does patient drive: □ no □ learner's permit □ licensed

Current Team Participation – Sport _______________________________ number practices/week ____________________________________

Other exercise and physical activity: (what, how often): ____

Any upcoming travel plans (next 2-3 weeks): ____

Any other upcoming plans (e.g., prom, homecoming, etc.): ____

Would you characterize patient as: □ "Driven" □ Easily stressed □ Perfectionistic? Does this child have trouble "pulling back?" □ No □ Yes

Any concerns about…. □ Behavior Problems □ Substance Use □ Social stress or bullying

____

____

Please list any other concerns, pertinent medical history or general comments ____

____

____

Anything you would like to discuss with me privately, without patient present? □ No □ Yes

IMPORTANT REMINDERS:

- If patient has been evaluated by other professionals for this injury, please provide copies of those records
- If patient has received ImPACT testing (often used by schools and teams for pre-season, baseline concussion testing), please provide all scores, including percentile ranks – you can also ask the test administrator to simply give you the patient's **ImPACT Passport ID#** - this is a unique identifier that allows me to obtain the scores myself from ImPACT
- If patient has had any other psychological, psychoeducational or neuropsychological testing – related to this injury or prior to it – please provide copies all reports since it will help me to understand the context and impact of the current injury
- If patient has any temporary or permanent school accommodations, for either pre-injury or post-injury issues (such as a 504 Plan, IEP, RTI plan, or physician-provided accommodation note), please provide copies of that documentation as well

All records and information listed above can be sent to me directly by email or fax prior to the appointment, or you can bring hard copies with you when we meet.

I have provided complete, true, and accurate information to the best of my knowledge. I also understand that information on this form, and any information provided as part of this evaluation/consultation, can be released only to individuals designated by me and with my written consent, and that my consent can also be revoked by me, in writing, at any time.

____ __________________________

Signature Date