CONCUSSION QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) If known, where was the location of impact/where did you hit your head?_____
2.) Is this a new presentation of a concussion, or a follow-up?_____
3.) Did another provider refer you? If yes, who?_____
4.) Describe **how** and **where** your concussion occurred? Be specific (include **dates**)

_____

_____

5.) Describe the concussion? (check all that apply)

__amnesia after the incident
__amnesia before the incident
__answering questions slowly
__being confused
__feeling dazed or stunned
__feeling forgetful
__feeling mentally foggy
__feeling slowed down
__having a seizure at the time of the incident
__having difficulty concentrating
__having difficulty remembering
__having drowsiness
__having loss of consciousness
__having trouble falling asleep
__having weakness or numbness in the arms or legs
__repeating questions
__sleeping less than usual
__sleeping more than usual
__slurring of speech
other:_____

6.) Are any of the following associated with the concussion?(check all that apply)

__a headache
__a skull fracture
__an intracranial injury
__balance issues
__dizziness
__drowsiness
__fatigue
__nausea
__numbness/tingling
__sensitivity to light
__sensitivity to noise
__visual problems
__vomiting
__worsening of symptoms with cognitive activity
__worsening of symptoms with physical activity
other:_____

7.) The concussion is best classified as?

__a concussion with LOC for greater than 1 minute
__a concussion with LOC for less than 1 minute
__a concussion without loss of consciousness

8.) How long ago was the concussion sustained? ___years ___months ___weeks ___days

9.) Which of the following applies to you? (check all that apply)

__history of anxiety
__history of ADHD
__history of depression
__history of learning disabilities
__history of migraine headaches
__history of sleep disorder
other:_____

10.) How severe is the pain on a scale of 0-10? (0 = no pain 10= worst pain)

currently ___/10 on a bad day ___/10 on an average day ___/10
initially ___/10 on a good day ___/10

11.) Have you had a prior concussion? If yes, how many? _____

12.) Have you had any of the following interventions for the concussion? (check all that apply)

__a brace __physical therapy __no treatment
__neuropsychological testing __Tylenol other:_____
__anti-inflammatory meds __narcotics/pain meds

13.) What diagnostic imaging studies have you had for this injury? (check all that apply)

__CT scan __neuropsychological testing __no imaging studies
__MRI __plain radiographs (X-ray) other:_____

14.) How has this problem limited you? (check all that apply)

__attending school on a limited basis __inability to perform ADL's __working on a limited basis
__difficulty with ADL's __inability to work __no limitations
__difficulty with REC sports participation __requiring constant assistance other:_____
__functional limitations __requiring occasional assistance
__inability to go to school __working light duty

15.) Who have you seen for this problem? (check all that apply)

__ER __another doctor __therapist __trainer __urgent care __walk-in clinic other:_____

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been acurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature	MD/PA Signature	Date

Recall Review Signatures: Date:

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2			
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