



Post-Injury Symptom Form

Name: _____ Date of Birth: _____

School: _____ Grade: _____ Average Grades: _____

Primary Care Physician (First and last name and location): _____

Parent's Email: _____

Drug allergies: No Yes (If yes, please list: _____) Current Medications: _____

Current/planned club/team sports (check all that apply):

	Basketball		Gymnastics		Rugby		Track
	Baseball		Dance		Soccer		Volleyball
	Cheerleading		Hockey		Softball		Wrestling
	Football		Horseback riding		Swimming		Other: _____ _____
	Golf		Lacrosse		Tennis		

History of PAST concussions (not including current): No Yes

If yes: # of other concussions: _____ # with loss of consciousness: _____ # in the last 3 months: _____

Have you ever been diagnosed with or treated for:

	Yes	No		Yes	No
ADD or ADHD			Migraine headaches		
Anxiety			Seizures		
Depression			Heart murmur		
Emotional or neurologic disorder			Fainting		
Dyslexia			Passed out with exercise		
Learning disability (please specify): _____			Allergies		
			Asthma		
Ocular dysfunction (please specify): _____			Immune disease or cancer		
			Other: _____		
History of vision therapy			_____		

Is there a FAMILY HISTORY (2 generations back) of:

	Yes	No		Yes	No
Seizures or epilepsy			Multiple sclerosis		
Depression			Dementia/Alzheimer's		
Suicide			ADD or ADHD		
Drug or alcohol dependence			Ocular dysfunction or vision therapy		
Parkinson's Disease			Migraine		

History of Current Injury

Date of Injury: _____ Activity that caused injury: _____

Loss of consciousness: No Yes Memory loss before injury: No Yes (If yes, how long _____)

Disorientation: No Yes Memory loss after injury: No Yes (If yes, how long _____)

History of Current Injury - continued

Mechanism of Injury: Head-head Head-ground Head-body part Head-ball
 Other: _____

Region of head hit: Front Side (front back right left) Back Top
 Other: _____

After Injury: Returned to play? No Yes Hospital? No Yes MRI/CT? No Yes

Symptom score (0-6)	In the FIRST 24 HOURS?	RIGHT NOW?
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Headache		
Neck Pain		
Nausea		
Vomiting		
Difficulty Balancing		
Dizziness		
Fatigue		
Sleep Disturbances		
Sleeping More		
Sleeping Less		
Drowsiness		
Sensitivity to Light		
Sensitivity to Noise		
Overall Emotionality		
Irritable		
Sadness		
Nervousness		
Depressed		
Numbness		
Tingling		
Feeling "Slowed Down"		
Feeling "Foggy"		
Difficulty Concentrating		
Difficulty Remembering		
Blurred vision		

Headache Details:

Description: dull aching throbbing sharp pressure-like other (_____)

Location: right side left side front back both sides around eyes other (_____)

Worsening factors: light noise movement stress exercise school concentration

Alleviating factors: medication (name: _____) darkness rest/quiet other (_____)

If no longer having headaches, date of last headache: _____