

What symptoms have you experienced as a result of this injury? _____

Have you ever had a concussion previously? YES _____ NO _____ If yes, how many, when and please describe each _____

What treatment, if any, have you received? _____

What is your primary language? _____ Do you speak any other languages? _____

Are you color-blind? YES _____ NO _____

MEDICAL HISTORY

Have you ever undergone any type of surgery? YES _____ NO _____ If yes, what type of operation did you have, how old were you, how long were you hospitalized, or was the surgery performed on an outpatient basis? _____

Have you suffered any other type of head injury? YES ___ NO ___ If yes, please indicate your age, how you were injured and whether or not consciousness was lost at the time of the incident, and if so, for how long:

Have you ever experienced seizures or convulsions? YES _____ NO _____ If yes, please explain:

Please place an "X" to indicate if you have had any of the following medical problems:

<input checked="" type="checkbox"/>	<u>Medical Condition</u>
	Attention Deficit/Hyperactivity Disorder (ADD or ADHD)
	Allergies
	Asthma
	Depression
	Diabetes
	Drug Use/Abuse
	Emotional Problems (depression/anxiety)
	Encephalitis
	Epilepsy
	Learning Disability
	Lead poisoning/exposure
	Migraines
	Multiple sclerosis
	Seizures
	Other (please specify)

PRESENT MEDICAL STATUS

Current Health: _____ (Please rate poor, fair, good, excellent, etc.)

Present height: _____ weight: _____

Are you in any way physically ill at this time? YES__ NO__ If yes, please explain and specify if you are currently being treated for this illness: _____

Please list any medication you are currently taking:

Medication Dose (e.g. 20mg four times a day) Date Started

Do you currently or have you ever smoked cigarettes? YES__ NO__ If yes, how much do you smoke per day and what brand of cigarettes? _____

On average, how much alcohol do you typically drink in one week? _____

Have you ever, or do you currently use any illegal drugs such as pot, coke, etc.? **(This information is used strictly to inform us of your medical condition and will not be shared with anyone without your permission, including the police.)** _____

Please place an "x" in the column if you have experienced any of the following the symptoms since the concussion (regardless if it is related to the concussion or not). For each one you check, rate how much you are experiencing the symptom TODAY, by rating it on a scale from 1 to 5 (1 = very little, 5 = very much)

<input checked="" type="checkbox"/>	SYMPTOM	RATE SYMPTOM 1 - 5
	Loss of Consciousness w/injury	NA
	No memory for injury	
	Headaches	
	Difficulty concentrating	
	Difficulty paying attention	
	Difficulty remembering things	
	Missed appointments	
	Feeling irritable	
	Difficulty sleeping (too much or not enough)	
	Difficulty falling asleep	
	Dizziness	
	Nausea	
	Vomiting	
	Problems with balance	
	Feelings of sadness	
	Numbness or tingling	
	Fatigue	
	Feeling mentally "slow"	
	Sensitive to light	
	Sensitive to noise	
	Double vision/blurry vision/ seeing spots	

Are you currently, or have you ever been involved in any type of professional mental health treatment (i.e., psychotherapy, family counseling, etc.)? YES _____ NO _____ If yes, please list: _____

EDUCATIONAL HISTORY:

Years of education: _____ Highest degree earned: _____

Name of School: _____

Did you repeat any grades? YES _____ NO _____ If yes, which ones and for what reason(s)? _____

Did you fail any subjects? YES _____ NO _____ If yes, which ones? _____

Did you receive special education services? YES _____ NO _____. If yes, specify type (i.e., self-contained class, resource room, reading or math lab, etc.):

Please indicate if you have ever had any of the following problems in school.

<input checked="" type="checkbox"/>	<u>Condition</u>
	Attention problems
	Discipline problems
	Failing grades
	Failing subjects
	Math difficulties
	Reading difficulties
	Social situations
	Writing difficulties

