

Concussion History

NAME: _____

DATE: _____

CURRENT CONCUSSION

Date of Onset:

Method of Onset:

Whiplash Y N

Direct Head Impact Y N

Blast Y N

Other: (Describe)

LOSS OF CONSCIOUSNESS: N Y How Long _____

Were You Hospitalized?

Insta-Care Y N

Emergency Department Y N

Other Facility Y N Describe:

Have you Had any Imaging Done? Y N List:

Have you Seen a Neurologist? Y N Name:

What Are Your Current Symptoms: (rate 0-10 with 10 being the worst)

Dizziness:

Nausea:

Head Ache:

Fogginess:

Any other symptoms you are experiencing now?

Do You Have Any of These?

Slurred Speech Y N

Severe/Worsening Headache Y N

Can't Recognize people Y N

Decreasing consciousness Y N

Seizures Y N

Increasing Confusion/Irritability Y N

Increasing Drowsiness Y N

Signs of Skull Fracture Y N

Vomiting x 2 since injury Y N

Unusual Behavior Change Y N

PAST CONCUSSION HISTORY

Please list approximate dates of any previous concussion you think you have had.