

Concussion/Mild Traumatic Brain Injury Intake Form

Please provide us with some information about your injury, if you do not understand a question, your therapist will assist you during the evaluation.

Name: _____

Date: _____ Age: _____

Date/Time of Injury: _____ Injury description: _____

- 1b. Location of Impact:** On the head- Front Left Front Right Front Left Back Right Back Back
 Other location- Neck Body
- 2. Cause:** Car accident Hit by a car Fall Assault Sports (specify) _____ Other _____
- 3. Are there any events just BEFORE the injury that you have no memory of (even brief)?** Yes No Duration _____
- 4. Are there any events just AFTER the injury that you have no memory of (even brief)?** Yes No Duration _____
- 5. Did you lose consciousness?** Yes No Duration _____
- 6. Early Signs:** Dazed or stunned Confused about events Slow to respond Dizzy Forgetful Repeating things
- 7. Were seizures observed?** Yes No If **yes**, please provide details _____
- 8. Did you receive medical attention at the time of the injury?** Yes No If **yes**, please explain, including any tests & results: _____

- Since the injury, have you experienced any of these symptoms more than usual today or in the past day?
- Headache Fatigue Difficulty Concentrating Drowsiness Sleeping more than usual
- Nausea Sensitivity to light Difficulty remembering Trouble falling asleep Sleeping less than usual
- Vomiting Sensitivity to noise Irritability
- Balance Problems Numbness/tingling Sadness
- Dizziness Feeling mentally foggy More emotional
- Visual Problems Feeling slowed down Nervousness
- Exertion:** Do these symptoms worsen with:

Physical Activity Yes No N/A

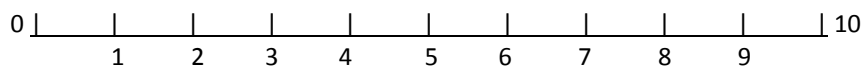
Concentration/thinking Yes No N/A

Has anything like this ever happened in the past? Y N
 If yes, how many times? 1 2 3 4 5 6+
 What's the longest you experienced symptoms? Days Weeks Months Years

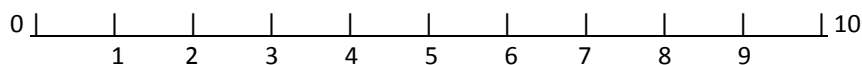
Vision	Headache (HA)	Developmental	✓	Psychiatric	✓
History of vision change or disturbance? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please explain: _____	Prior treatment for HA? <input type="checkbox"/> Y <input type="checkbox"/> N	Learning disabilities		Anxiety	
	History of migraine headache <input type="checkbox"/> Personal <input type="checkbox"/> Family	ADD/ADHD		Depression	
		Other Developmental Disorder _____		Sleep Disorder	
				Other psychiatric disorder	

How do you learn best? By:
 Hearing it Reading it Seeing it demonstrated Performing it yourself Observing someone else

Rate your average pain or symptom on a scale of 0-10 with "**0**" equals to no pain and "**10**" equals the worst imaginable.
 → Mark the line at the point that represents your pain or symptom.



Rate how near you are to your **normal function** on a scale of 0-10 by with "**0**" equals not able to perform **any** of your normal activities and "**10**" equals able to do **all** normal activities without difficulty. → Mark the line at the point that represents your level of function.



Which skills or abilities do you hope to regain by coming to therapy? _____

Which of the following over the counter medications are you taking or have taken in the last week?

- Ibuprofen (Advil) Antihistamines Decongestants Naturopathic Vitamins Antacids
 Aspirin Laxatives Tylenol Naproxen Sodium (Aleve) Other: _____

Which of the following prescription medications are you taking?

- Allergy Hormones Pain Tone/Spasticity Reduction Other: _____
 Antibiotic Diabetes Reflux Cholesterol _____
 Anti-inflammatory Depression Seizure Thyroid
 Blood Pressure Respiratory Anti-nausea Bladder
 Heart Muscle Relaxant Blood Thinners MS Med/Fatigue

Medical History: For new patients only or those treated prior to June 2008

- ADD/AHD Dizziness Neurological Condition: _____
 Amputation DVT's Noise Exposure
 Autism Failure to Thrive Osteoarthritis
 Auto Immune Disease: _____ Falls Osteoporosis
 Balance Problems Feeding/Swallowing Problems Psychological Condition: _____
 Bowel/Bladder Problems Fibromyalgia Respiratory Condition: _____
 Cancer: _____ Fractures: _____ Rheumatoid Arthritis
 Cardiac Condition: _____ Gastrointestinal: _____ Seizures
 Chemical Dependency Hepatitis Sleep disturbances
 Chronic Otitis Media Hearing Loss Thyroid
 Cleft Palate Headaches/Migraines TMJ
 Dementia High Blood Pressure (Hypertension) Vision
 Depression Labor/Delivery Complication Voice
 Diabetes Other: _____

Do you have any known allergies: Drug _____ Food _____ Other _____

Social History:

1. Support system:
 Married Single Widowed Significant other: _____
2. Living arrangement:
 Home/alone Home w/family Assisted living center Adult Foster home
 Children at home #: _____ Ages of Children _____
3. Amount of help currently needed at home:
 None Part of the day During the day During the night 24 hours a day
4. Home Accessibility:
 # of Stairs/Steps Walk-in Shower Rail Tub/shower combination
5. Assistive Devices/Equipment:
 Cane Bath bench Resting splints Walker Brace
 Raised toilet seat Commode Prosthesis Wheelchair/scooter Grab bars
 Hospital bed Dressing equipment Hearing aids Glasses Lifeline

Work History: Occupation: _____

- Current Status? Full duty Temporary disability Permanent disability Applied for disability
 Retired Volunteer Light duty Modified duty/job restrictions are: _____

Anticipated return to work date or work status change? _____

Physician follow-up: Physician recheck is scheduled for this date: _____

SIGNATURE: _____



I. Demographic and Background Information

School / Organization: _____

2015

Date of Birth: _____ month _____ date _____ year

Date

First Name: _____ Last Name: _____

Height: _____ ft _____ in Weight: _____ Gender: _____ male _____ female

Handedness: _____ right _____ left _____ ambidextrous (both right and left)

Native Country / Region: _____

Native Language: _____

Second Language: _____ (only if fluent in speaking and writing)

Years of education completed excluding kindergarten: _____

(e.g., high school senior is 11 years)

Check any of the following that apply:

- _____ Received speech therapy
- _____ Attended special education classes
- _____ Repeated one or more years of school
- _____ Diagnosed attention deficit disorder or hyperactivity
- _____ Diagnosed learning disability

While in school, what type of student were / are you?

_____ Below Average _____ Average _____ Above Average

Current Sport: _____

Current position / event / class: _____

(e.g., quarterback, forward, 1st base, etc.)

Current level of participation: _____ (e.g., junior high, high school)

Years of experience at this level: _____ (0 - 4)

(e.g., number of years in high school, high school senior = 3)

Please list your 5 most recent concussions:

_____	month	_____	year
_____	month	_____	year
_____	month	_____	year
_____	month	_____	year
_____	month	_____	year

Concussion History

- _____ Number of times diagnosed with a concussion (excluding current injury)
- _____ Total number of concussions
- _____ Total number of concussions that resulted in confusion
- _____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately after injury
- _____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately before injury
- _____ Total number a games that were missed as a direct result of all concussions combined

I. Demographic and Background Information (cont.)

Baseline Worksheet

Indicate if you have had any of the following:

- yes no Treatment for headaches by physician
 yes no Treatment for migraine headaches by physician
 yes no Treatment for epilepsy / seizures
 yes no Treatment for brain surgery
 yes no Treatment for meningitis
 yes no Treatment for substance abuse / alcohol abuse
 yes no Treatment for psychiatric condition (depression, anxiety)

Have you been diagnosed with any of the following?

- yes no ADD/ ADHD
 yes no Dyslexia
 yes no Autism

Have you participated in any strenuous exercise and/or exertion in the last 3 hrs?

yes no

Date of your last concussion: _____ month _____ date _____ year

Number of hours slept last night: _____ (approximate if uncertain)

Please list any **PRESCRIPTION** medication (s) you are currently taking:

2015

Date

Parent/Guardian

PARENT/GUARDIAN SIGNATURE