Florida Functional Neurology Group

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RESET FORM

Name: _____

Date: _____ Age: _____

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.

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 SELECT ONE
Concentration/thinking SELECT ONE

Has anything like this ever happened in the past? SELECT ONE
If yes, how many times? SELECT ONE
What's the longest you experienced symptoms? ◯ Days ◯ Weeks ◯ Months ◯ Years

Vision	Headache (HA)	Developmental	✓	Psychiatric	✓
History of vision change or disturbance? ◯ Y ◯ N	Prior treatment for HA? ◯ Y ◯ N	Learning disabilities	☐	Anxiety	☐
If yes, please explain: _____	History of migraine headache	ADD/ADHD	☐	Depression	☐
_____	☐ Personal ☐ Family	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.

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 SELECT ONE

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.

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 SELECT ONE

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

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Get Assessed Like the Pros! ImPACT™

Baseline Worksheet

I. Demographic and Background Information

Today's Date 2015

Date

School / Organization: _____

Date of Birth: _____ month _____ date _____year

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

RESET THIS FORM COMPLETELY

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:

_____
_____
_____

Today's Date 2015

Date

_____

Parent/Guardian PARENT/GUARDIAN SIGNATURE