SPORTSSAFE
Concussion. Brain. Body.

Post-Injury Symptom Form

Name: _____ Date of Birth: _____

School: _____ Grade: 5th Average Grades: A/B's

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?
Headache	0 = no symptoms	0 = no symptoms
Neck Pain	0 = no symptoms	0 = no symptoms
Nausea	0 = no symptoms	0 = no symptoms
Vomiting	0 = no symptoms	0 = no symptoms
Difficulty Balancing	0 = no symptoms	0 = no symptoms
Dizziness	0 = no symptoms	0 = no symptoms
Fatigue	0 = no symptoms	0 = no symptoms
Sleep Disturbances	0 = no symptoms	0 = no symptoms
Sleeping More	0 = no symptoms	0 = no symptoms
Sleeping Less	0 = no symptoms	0 = no symptoms
Drowsiness	0 = no symptoms	0 = no symptoms
Sensitivity to Light	0 = no symptoms	0 = no symptoms
Sensitivity to Noise	0 = no symptoms	0 = no symptoms
Overall Emotionality	0 = no symptoms	0 = no symptoms
Irritable	0 = no symptoms	0 = no symptoms
Sadness	0 = no symptoms	0 = no symptoms
Nervousness	0 = no symptoms	0 = no symptoms
Depressed	0 = no symptoms	0 = no symptoms
Numbness	0 = no symptoms	0 = no symptoms
Tingling	0 = no symptoms	0 = no symptoms
Feeling “Slowed Down”	0 = no symptoms	0 = no symptoms
Feeling “Foggy”	0 = no symptoms	0 = no symptoms
Difficulty Concentrating	0 = no symptoms	0 = no symptoms
Difficulty Remembering	0 = no symptoms	0 = no symptoms
Blurred vision	0 = no symptoms	0 = no symptoms

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: _____