The Rehab Doctors PC

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This questionnaire is a part of your permanent medical record. Please use ink pen and write legibly.

Patient Name: _____ Date: _____

Telephone #: _____ Age: _____ DOB: _____

A. Injury Characteristics **Date/Time of Injury:** _____

Reporter: ___ **Patient** ___ **Parent** ___ **Spouse** ___ **Other** ___

1. Injury Description

_____

_____

1a. Is there evidence of injury to the head (direct or indirect)? ___ Yes ___ No ___ Unknown
1b. Is there evidence of intracranial injury or skull fracture? ___ Yes ___ No ___ Unknown
1c. Location of Impact: ___ Frontal ___ Left ___ Right ___ Back of Head ___ Neck ___ Indirect Force
2. Cause: ___ MVC ___ Fall ___ Sports (specify) _____
3. Amnesia Before (Retrograde) Are there any events just BEFORE the injury that you/person has no memory of (even brief)?
___ Yes ___ No Duration:
4. Amnesia After (Anterograde) Are there any events just AFTER the injury that you/person has no memory of (even brief)?
___ Yes ___ No Duration:
5. Loss of Consciousness: Did you/person lose consciousness?
___ Yes ___ No Duration:
6. EARLY SIGNS: ___ Appears dazed or stunned ___ Is confused about events ___ Answers questions slowly
___ Repeats Questions ___ Forgetful (recent info)
7. Seizures: Were seizures observed? No ___ Yes ___ Detail: _____

_____

B. Symptom Check List* Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day?
Indicate presence of each symptom (0 = No, 1 = Yes) ***Lovell & Collins, 1998 JHTR**

PHYSICAL (10)		COGNITIVE (4)		SLEEP (4)		
Headache	0 1	Feeling mentally foggy	0 1	Drowsiness	0 1	
Nausea	0 1	Feeling slowed down	0 1	Sleeping less than usual	0 1	N/A
Vomiting	0 1	Difficulty concentrating	0 1	Sleeping more than usual	0 1	N/A
Balance Problems	0 1	Difficulty remembering	0 1	Trouble falling asleep	0 1	N/A
Dizziness	0 1	**COGNITIVE Total (0-4)** _____		**SLEEP Total (0-4)** _____		
Visual Problems	0 1	**EMOTIONAL (4)**				
Fatigue	0 1	Irritability	0 1			
Sensitivity to light	0 1	Sadness	0 1			
Sensitivity to noise	0 1	More emotional	0 1			
Numbness/Tingling	0 1	Nervousness	0 1			

PHYSICAL Total (0-10) _____	**EMOTIONAL Total (0-4)** _____
(Add Physical, Cognitive, Emotional, and Sleep totals) Total Symptom Score (0-22)	

Exertion: Do these symptoms worsen with:
Physical Activity ___ Yes ___ No ___ N/A
Cognitive Activity ___ Yes ___ No ___ N/A

Overall Rating: How different is the person acting compared to his/her usual self? (circle)

Normal 0 1 2 3 4 5 6 Very Different

C. Risk Factors (check all that apply)

Concussion History? Y ___ N ___	**Headache History?** Y ___ N ___	**Developmental History**	**Psychiatric History**
Previous # 1 2 3 4 5 6+	Prior treatment for headache	Learning disabilities	Anxiety
Longest symptom duration Days ___ Weeks ___ Months___ Years ___	History of migraine headache ___ Personal ___ Family _____ _____ _____	Attention-Deficit/Hyperactivity Disorder	Depression _____ Sleep disorder
If multiple concussions, less force caused re-injury? Yes ___ No ___		Other developmental disorder _____	Other psychiatric disorder _____

List other medical disorders or medication usage (e.g., hypothyroid, seizures)_____
_____

D. Previous Image			**Location**
MRI	Yes	No	
CT Scan	Yes	No	
X-Ray	Yes	No	

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