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Department of Neurology

**Adult (Age 15 and up) Concussion New Patient**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work/School: Full time Part Time Where: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language(s) other than English spoken in home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mechanism of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of Consciousness? Yes No Do you recall impact? Yes No

Were you removed from sport/play due to injury? Yes No

Please list ALL concussion dates and length of recovery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Indicate whether you had any of the following (Circle one):*

Chronic Headaches (non-concussion related)? Yes No

Chronic Migraines Yes No

Epilepsy/Seizures Yes No

Brain Surgery Yes No

Sleep Disorder (ex: Insomnia, Sleep Apnea) *If yes, What type? \_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_Yes No

Meningitis Yes No

Substance Abuse/ETOH Abuse Yes No

Mental Health Condition (anxiety, depression etc.) Yes No

*If yes, which type(s)?:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History of any of the above: Yes No

*If yes, which ones(s)?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgical History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Food Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Diet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tested positive at any point for COVID-19? Yes No; If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with ADD/ADHD? Yes No

Have you ever been diagnosed with Dyslexia? Yes No

Have you ever been diagnosed with Autism? Yes No

Have you ever been diagnosed with a learning disability/issue(s)? Yes No

*If yes, what type?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received Speech Therapy? Yes No

Did you had an IEP/504 plan in school? Yes No

Have you repeated one or more years of school? Yes No

Military Service? Yes No

Did you play a sport in College? Yes No

If Yes; what sport(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When in school, what type of student were/are? A’s & B’s B’s and C’s C’s & D’s D’s and F’s

What year did you graduate from High School? \_\_\_\_\_\_\_\_\_\_\_\_; Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you attend College? Yes No Some College; (list all degrees)

Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol: None Yes How much/often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco: Never Yes How much/long\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marijuana: None Yes How much\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational Drugs: None Yes Which ones:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitamins/Herbals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep:**How Many Hours:\_\_\_\_\_Trouble Falling Asleep: No Yes Wake up frequently: No Yes

**Screen Time:** How Many Hours:\_\_\_\_\_\_\_\_

*Please circle the early signs that were reported after the injury:*

Headache Appeared dazed/confused Sensitivity to light Sensitivity to noise

Balance issues Confused about events Dizziness Fogginess

Irritability Answered questions slowly Visual Changes Forgetful

Neck pain Repeated questions Nausea Vomiting

*Where was the location of your impact?*

No head impact Front of head Back of head Left side of head

Right side of head Unsure

*Who have you been evaluated by?*

Primary Care Physician Athletic Trainer Emergency Center Urgent Care

Other/Physician/NP/PA

*Who recognized that you had a concussion?*

Athletic trainer Coach Self Spouse Parent Teacher Teammate Other: \_\_\_\_\_\_

*Have you returned to work?*

Full day Half Day Not Working

Have you returned to any Physical activity/Exercise after the injury? Yes No

Have you had any imaging (ex: MRI, CT scan)? Yes No

If yes, what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable: What was the first day of your last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable: How many periods have you had in the last 12 months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable: What age were you at your first period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Symptoms Today** | 0 (None) | 1 (Mild) | 2 | 3 Mode | 4 rate | 5 | 6 (Severe) |
| Headaches | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Pressure in Head | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Neck Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Nausea | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Vomiting | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Dizziness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Blurred Vision | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Balance Problems | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sensitivity to Light | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sensitivity to Sound | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Feeling like “in a fog” | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Difficulty Concentrating | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Difficulty Remembering | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Fatigue/Low Energy/Slowed Down | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Confusion | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Drowsiness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| More Emotional | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| More Irritable | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sadness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Nervous/Anxious | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sleep Disturbance | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Abnormal Heart Rate | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Excessive Sweating | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Do symptoms worsen with physical activity? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Do symptoms worsen with cognitive (thinking) activity? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| How normal (your baseline) do you feel? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

*Have you had any other symptoms/injuries in association with you head injury not reported above?*

Loss of appetite w/o Nausea Indigestion Weight Loss Ringing in the ear

Neck Pain Back Pain Speech Issues Feeling Clumsy Skull Fracture

Brain Bleed Seizure Pain in arm, legs or joints Chest pain Ear Pain

Stomach or Bowel Problems Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHQ-9 Depression Screening**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the **last 2 weeks**, how often have you been bothered by any of the following problems? | Not at all | Several Days | More than half of the days | Nearly Every day |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed or being so fidgety/restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

**GAD-7 Anxiety Screening**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the **last 2 weeks**, how often have you been bothered by any of the following problems? | Not at all | Several Days | More than half of the days | Nearly Every day |
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Worrying too much about different things | 0 | 1 | 2 | 3 |
| Trouble relaxing | 0 | 1 | 2 | 3 |
| Being so restless that it’s hard to sit still | 0 | 1 | 2 | 3 |
| Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

**MIDAS**

Please answer the following questions about ALL of the headaches you have had over the **last 3 months.** Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months.

\_\_\_\_\_1. On how many days in the last 3 months did you miss work or school because of your headaches?

\_\_\_\_\_2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

\_\_\_\_\_3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

\_\_\_\_\_4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

\_\_\_\_\_5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

Total Score: 0-5 6-10 11-20 21+

**Pittsburgh Sleep Quality Index**

|  |  |
| --- | --- |
| During the past week how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.) | |
| 5 to 6 hours | 4 |
| 6 to 7 hours | 3 |
| 7 to 8 hours | 2 |
| 8 to 9 hours | 1 |
| More than 9 hours | 0 |
| How satisfied/dissatisfied were you with the quality of your sleep? | |
| Very dissatisfied | 4 |
| Somewhat dissatisfied | 3 |
| Somewhat satisfied | 2 |
| Satisfied | 1 |
| Very satisfied | 0 |
| During the recent past, how long has it usually taken you to fall asleep at each night? | |
| Longer than 60 minutes | 3 |
| 31-60 minutes | 2 |
| 16-30 minutes | 1 |
| 15 minutes or less | 0 |
| How often do you have trouble staying asleep? | |
| Five to seven times a week | 3 |
| Three or four times a week | 2 |
| Once or twice a week | 1 |
| Never | 0 |
| During the recent past, how often have you taken medicine to help you sleep? (prescribed or over the counter) | |
| Five to seven times a week | 3 |
| Three or four times a week | 2 |
| Once or twice a week | 1 |
| Never | 0 |