Office-Based Concussion Evaluation

(For use in clinic setting)

Name:_______________ Referral Source: _______________ N/A

DOB: ________ Age: ______ Level of Education:______School: _______________

Date of Evaluation (Today's Date): ________Date of Injury: ________ Time Since Injury: ___________

Person Reporting: ____ Patient ____Parent____ Spouse ____ ATC __________ Other ___________

Cause: ____ MVA _____ Ped-MVA ____Fall ____Assault ____ Sport (specify) _______________

___ Practice _____Game   Position: ___________   Mouthguard: Y / N Type: bite & boil custom

Mechanism of Injury: __Head to Head ___Head to Ground ____Head to Body Part _______ Other ___________

Location of Contact: __ Frontal ____R / L Temporal____ R /L Parietal ___ Occipital____ Neck Other ___________

Injury Description:_______________________________________

____

Loss of Consciousness: Y / N Duration: _______________

Amnesia (Retrograde): Loss of memory of events **before** the injury? Y / N Duration: ___________

Amnesia (Anterograde): Loss of memory of events **after** the injury? Y / N Duration: ___________

Early Signs: __Dazed or stunned___ Confused or disoriented___ Answered questions slowly ___ Repeated questions __Forgetful

Seizures: Were seizures observed? Y / N **Same Day Return-to-Play** Y / N Describe:___________

Overall, how severe would you rate your problems with this injury? 0 1 2 3 4 5 6

Previous Provider: ___________Date:________ CT or MR Imaging ___ Yes___No Results: ________

Symptom Check List: Initial (day of injury) and Current (at the time of evaluation) – Rate severity on scale from 0-6

Physical (10)	Initial	Current	Cognitive(4)	Initial	Current	Sleep (4)	Initial	Current	NA
Headache			Feeling mentally foggy			Drowsiness			
Nausea			Feeling slowed down			Sleeping less than usual			
Vomiting			Difficulty concentrating			Sleeping more than usual			
Balance problems			Difficulty remembering			Trouble falling asleep			
Dizziness			**COG Total Score**			**SLEEP Total Score**			
Visual problems			**COG Total Symptoms**			**SLEEP Total Symptoms**			
Fatigue			**Emotional (4)**	**Initial**	**Current**				
Sensitivity to light			Irritibility						
Sensitivity to noise			Sadness						
Numbness/Tingling			More emotional						
			Nervousness						
PHYS Total Score			**EMO Total Score**						
PHYS Total Symptoms			**EMO Total Symptoms**						
TOTAL SCORE			**TOTAL SYMPTOMS**						

Do these symptoms get worse with physical activity? Y / N / NA

Do these symptoms get worse with cognitive activity? Y / N / NA

Headache
Type: Throbbing/Pressure/Dull
Location: R or L Top/Frontal/Parietal/
Occipital/Generalized
Neck Pain? Y / N
Worse in AM / PM
Heachache worse with cognitive exertion? Y / N
Describe:

Headache worse with physical exertion? Y / N
Describe:

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Risk Factors for Protracted Recovery (Check all that Apply)

Concussion history Y / N	Development history	Psychiatric history	Headache history
Previous # 1 2 3 4 5 6+	Learning disabilities	Anxiety/Depression	Prior tx for HA
Longest symptom duration Days______ Weeks______ Months______ Years______	Attention-Deficit/ Hyperactivity Disorder	Sleep Disorder	History of migranes
If multiple concussions, did less force cause reinjury? Y / N	Other developmental disorder:	Other psychiatric disorder:	Family history of migraines or headache

Medications: ____

Other medical history: ____

Immediate Memory (Circle 'C' if correct, 'I' if incorrect)

I am going to read to you a list of words and, when I am done, repeat as many words as you can remember in any order. (Repeat process for trial 2 and 3).

List	Trial 1		Trial 2		Trial 3		Alternative Word Lists		
Elbow	C	I	C	I	C	I	Candle	Baby	Finger
Apple	C	I	C	I	C	I	Paper	Monkey	Penny
Carpet	C	I	C	I	C	I	Sugar	Perfume	Blanket
Saddle	C	I	C	I	C	I	Sandwich	Sunset	Lemon
Bubble	C	I	C	I	C	I	Wagon	Iron	Insect

Concentration (Circle 'C' if correct, 'I' if incorrect)

I am going to read to you a string of numbers and, when I am done, you repeat them back to me backwards, in reverse order of how I read them to you. For example, if I say 719 you would say 917.

List	Trial		Alternative Number Lists		
4-9-3	C	I	6-2-9	5-2-6	4-1-5
3-8-1-4	C	I	3-2-7-9	1-7-9-5	4-9-6-8
6-2-9-7-1	C	I	1-5-2-8-6	3-8-5-2-7	6-1-8-4-3
7-1-8-4-6-2	C	I	5-3-9-1-4-8	8-3-1-9-6-4	7-2-4-8-5-6

	Normal	Abnormal
General appearance		
Describe:		

Pupil / Eye Exam

Pupil appearance		Eyes	Normal	Abnormal
Dilated		Reaction		
Constricted		Horizontal motion		
Nystagmus		Unequal		

Motor and Balance	Normal	Abnormal
Fine movement of hands		
Finger-to-nose task		
Gait		
Tandem walk		
Rhomberg test		
Advanced balance testing*		

*Have athlete stand heel-to-toe with eyes closed, and hands on hips, for 20 seconds while trying to maintain stability (Non-dominant foot in back)

Delayed Recall (Circle 'C' if correct, 'I' if incorrect)

Do you remember that list of five words I read earlier?
Tell me as many words from the list as you can remember, in any order

List	Trial		Alternative Word Lists		
Elbow	C	I	Candle	Baby	Finger
Apple	C	I	Paper	Monkey	Penny
Carpet	C	I	Sugar	Perfume	Blanket
Saddle	C	I	Sandwich	Sunset	Lemon
Bubble	C	I	Wagon	Iron	Insect

Follow-up Plan

___ No follow-up needed, unless signs or symptoms return
___ Follow-up in clinic: Time until next follow-up ______________________
___ Referral to Sports Concussion Clinic
___ Other Referral
    ___ Neuropsychology   ___ Neurosurgery
    ___ Neurology   ___ Physiatry
    ___ Physical Therapy   ___ Speech Therapy
    ___ Other: ______________________
___ CT / MRI
___ Emergency Department

Report Completed by ____