Office-Based Concussion Evaluation (For use in clinic setting)

Name:	Referral Source:							
DOB:Age:Leve	el of Education:	_School:						
Date of Evaluation (Today's Date): Date of Injury: Time Since Injury:								
Person Reporting:PatientParentSpouseATCOther								
Cause: MVA Ped-MVAFa	lAssault Sport	(specify)						
PracticeGame Position:	Mou	thguard: Y / N Type: bite & boil cust	om					
Mechanism of Injury:Head to Head	_Head to GroundHe	ad to Body Part Other						
Location of Contact: FrontalR / L	Temporal R /L Pari	etal Occipital Neck Other						
Injury Description:								
Loss of Consciousness: Y / N Duration:								
Amnesia (Retrograde): Loss of memory of	f events before the injury	? Y / N Duration:						
Amnesia (Anterograde): Loss of memory	of events after the injury	? Y / N Duration:						
Early Signs:Dazed or stunnedConfu	sed or disoriented An	swered questions slowly <u>Repeated qu</u>	estions Forgetful					
Seizures: Were seizures observed? Y / N	Same Day Return-to-P	lay Y / N Describe:						
Overall, how severe would you rate your pro-	blems with this injury? 0	1 2 3 4 5 6						
Previous Provider:	Date: CT	or MR Imaging YesNo Result	s:					

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	nt Headache			
Sensitivity to light			Irritibility			Type: Throbbing/Pressure/Dull — Location: R or L Top/Frontal/Parietal/ Occipital/Generalized			
Sensitivity to noise			Sadness						
Numbness/Tingling			More emotional			Neck Pain? Y / N			
			Nervousness			Worse in AM / PM Heachache worse with cognitive exertion? Y Describe:			v / N
PHYS Total Score			EMO Total Score						1 / IN
PHYS Total Symptoms			EMO Total Symptoms						
TOTAL SCORE TOTAL SYMPTOMS						Headache worse with physi	cal exe	rtion? Y	/ N
Do these symptoms get worse with physical activity? Y / N / NA				Describe:			,		
Do these symptoms get worse with cognitive activity? Y / N / NA									

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:

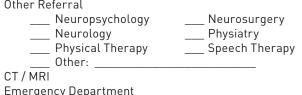
Immediate Memory (Circle 'C' if correct, 'I' if incorrect) I am going to read to you a list of words and, when I am done, repeat as many words as you can remember in any order. (Repeat process for trial 2 and 3).									
List Trial 1 Trial 2 Trial 3 Alternative Word Lists									
Elbow	С	Ι	С	Т	С	Ι	Candle	Baby	Finger
Apple	С	Ι	С	I	С	Ι	Paper	Monkey	Penny
Carpet	С	Т	С	Ι	С	Ι	Sugar	Perfume	Blanket
Saddle	С	T	С	T	С	Ι	Sandwich	Sunset	Lemon
Bubble	С	Ι	С	Ι	С	Ι	Wagon	Iron	Insect

	Normal	Abnormal
General appearance		
Describe:		

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)							

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



 Emer	yency	Depai	un

Report Completed by_____

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	Tr	ial	al Alternative Number Lists						
4-9-3	С	I	6-2-9 5-2-6 4-1-5						
3-8-1-4	С	Ι	3-2-7-9	1-7-9-5	4-9-6-8				
6-2-9-7-1	С	Ι	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									

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

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