Post-Concussion Evaluation Form

Name:________________________________ **Date:**________________

Age:________ Sex: M F Height: ______ Weight: _____ Dominant hand: R L

SCHOOL INFORMATION: Grade:______ School:_________________________

WORK INFORMATION: Do you have a job: Y N If yes, job: _______________________

SPORT INFORMATION: Current sport(s) and/or activities: ____________________________

Position(s) played/event(s):______________________ How long have you been playing:_____

Team name(s):____

HISTORY OF INJURY: How did your problem occur?:_______________________________

____

Date of Onset:_____________ Involved Side: R L Both Next Physician Follow-up:_____

Describe any previous problems with this area: ____

MEDICAL INFORMATION: Family Physician:______________________________________

Referring Physician:____________________ Diagnosis: ______________________________

Medical Tests: X-Ray___ CT Scan___ Bone Scan___ MRI___ EMG___ NCV___ ImPACT___
Arthrogram___ Ultrasound___ Other:_________________ Results:_________________

Did you have surgery? Y N Date:_____/_______/_________

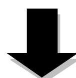
Did you use: Cast ____Splint___ Brace___ Boot___ Date Used:___/___/____ - ___/___/___

Do you drink or smoke: Y N **Females:** Have you started menstruating? Y N Age of first period: ___

Have you ever been diagnosed with any of the following conditions?

__Y	__N	Cancer (Type:___________)	__Y	__N	Juvenile Rheumatoid Arthritis
__Y	__N	Heart or Circulation Problems	__Y	__N	Other Arthritic Conditions
__Y	__N	High Blood Pressure	__Y	__N	Mononucleosis
__Y	__N	Depression/Anxiety/OCD (Circle)	__Y	__N	Ehler's Danlos/Hypermobility
__Y	__N	Asthma (Worse with:___________)	__Y	__N	Latex Allergy
__Y	__N	Allergies	__Y	__N	Anemia
__Y	__N	Disordered Eating	__Y	__N	Osteoporosis/Osteopenia/Stress fractures
__Y	__N	Urinary Leakage/Pelvic Floor Issues	__Y	__N	Lyme disease
__Y	__N	Thyroid Problems	__Y	__N	Learning disability/ADHD
__Y	__N	Diabetes (Type I/II)	__Y	__N	Concussion (#:________)

Please turn over and complete the other side



List any medications (including prescriptions, over-the-counter, herbals, vitamin/mineral/dietary supplements) you are currently taking:

	Name of Med./Supplement	Dosage	Frequency of Use	Route of Administration
1.	___________________________	________________	________________________	________________________
2.	___________________________	________________	________________________	________________________
3.	___________________________	________________	________________________	________________________
4.	___________________________	________________	________________________	________________________
5.	___________________________	________________	________________________	________________________

FUNCTION: Indicate any activities that you have difficulty completing (walking, sitting, running, standing, climbing stairs, sports, school, lifting, carrying, driving, position changes, reading, computer use, throwing, squatting, cutting, pivoting, jumping, sleeping, dressing, reaching):

____

What are your goals for Physical Therapy? ____________________________________

SYMPTOMS:

Circle the amount of your pain at best- (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Circle the amount of your pain at worst- (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Circle the amount of your symptoms at rest- (No Pain)0 1 2 3 4 5 6 7 8 9 10 (Unbearable)
Circle the amount of your symptoms with activity- (No Pain)0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Are your symptoms: Constant____ Intermittent____

Symptoms: Headache Dizziness Disorientation Nausea/vomiting Imbalance

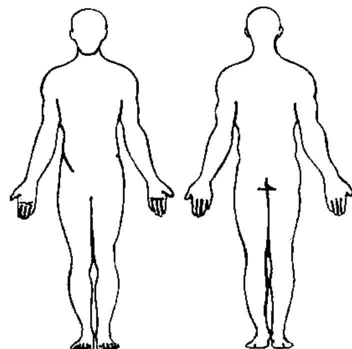
Memory loss Hearing Loss Vision changes Other

Since onset, symptoms have: Improved Worsened No change Other

Activities that increase symptoms:____
Activities that decrease symptoms:____

Please mark on the drawing and/or lists below the areas where you feel your pain:

Head/neck: Y N
Upper/mid back: Y N
Low back: Y N
Shoulders: Y N
Elbows: Y N
Wrists/hands: Y N
Hips: Y N
Knees: Y N
Ankles/feet: Y N
Other: Y N



Other Concerns/Questions:________________
____
____
____
____
____
____
____
____

Please tell us how you heard about us!

Please circle your response below (please circle all that apply):

Family physician/pediatrician

Specialist/orthopedist

Other medical provider (neurologist, rheumatologist, dentist, orthodontist, chiropractor, etc)

Athletic trainer

Coach

Massage therapist

Friend or family member

Flyer or other marketing material

Prior patient

Injury prevention program with your sports team

Other: ________________

Please tell us the name of your referral source so we can thank them: ____________________________