Concussion New Patient Form

Today's Date ___________________________
Name ___________________________________
Address ________________________________
Birth date _____________________________
Age ____________ Gender ________________
Referred by ____________________________

Mom's Name _____________________________
Mom's Cell Phone _______________________
Dad's Name _____________________________
Dad's Cell Phone _______________________
Family Physician name __________________
Family Physician phone _________________

CURRENT MEDICAL HISTORY:

Date/Time of Head Injury: ________________________ Occurred during what activity: _______________

Injury Description: ____

____

Signs present immediately after head trauma:

___Dazed or stunned; ___ Confused about events; ___ Was slow to respond; ___Dizzy/balance issues;

___Loss of memory before or after event; ___Forgetful or repeated questions/statements

Did you receive medical attention at the time of the injury: _____________________________________

If so, by whom: ____

Have you received any other medical care since the injury: ______________________________________

If so, by whom and what was done: ____

Current medication use (names and doses): ____

SCHOOL INFO:

School Name: _________________________

School Class Schedule:

____
____
____
____
____
____

GPA before injury: ______________________

Grade: __________________________________

School Contacts (name and contact number):

Counselor: ______________________________
Trainer: ________________________________
Nurse: _________________________________
Psychologist: ____________________________
Other: _________________________________

Attend classes since injury: _________________

Did you have IEP/504 plan before injury: _____

SPORTS TEAMS CURRENTLY INVOLVED IN:

Team/Activity Name	Location/Address	Season	Coach/Contact

PAST MEDICAL HISTORY:

Vision	Headache (HA)	Developmental	Psychiatric
History of vision change or disturbance? □ Y □ N	Prior treatment for HA? □Y □ N	Learning Disabilities □ Y □ N	Anxiety □ Y □ N
If yes, please explain: ______	History of migraine headache: □ Personal □ Family	ADD/ADHD □ Y □ N	Sleep Disorder □ Y □ N
______________________	______________________	Other Developmental Disorders:__________	Other psychiatric disorders: ______________________

Past Concussion/Head Injury (date/age):__________________ Time for recovery: ___________________

Past Concussion/Head Injury (date/age):__________________ Time for recovery: ___________________

Past Concussion/Head Injury (date/age):__________________ Time for recovery: ___________________