Ascension Medical Group-Orthopaedics & Sports Medicine
CONCUSSION INTAKE FORM

Appointment Date: ____________________

Name: __________________________ **DOB:** ____________ **Age**: _____ **BMI**: ____

Primary Care Doctor: ____________________ **Referring Doctor:** ____________________

Primary Care Doctor Last Visit: _______________

Red Flag Symptoms reported: Please see below:

- **Seizure/Burning Pain/Tingling** ▢Yes or ▢No
- **Severe Headache** ▢Yes or ▢No
- **Focal Neurologic Deficits on Exam** ▢Yes or ▢No
- **Unequal pupils and Double Vision** ▢Yes or ▢No
- **Significant Drowsiness** ▢Yes or ▢No
- **Slurred Speech** ▢Yes or ▢No
- **Poor orientation** ▢Yes or ▢No
- **Neck Pain** ▢Yes or ▢No
- **Repeated Vomiting** ▢Yes or ▢No

CONCUSSION HISTORY/HEAD INJURY HISTORY
Date of Injury: **Time of Injury:** ▢AM ▢PM
How did it happen:
Mechanism of Injury is result of: ▢Car Accident ▢Work Accident ▢Accident ▢Sports Injury
Loss of Consciousness: ▢Yes or ▢No
Duration of Loss of Consciousness: **(min/hours)** ▢Not Applicable
Did you seek medical attention immediately:
Did you complete the game / activity: ▢Yes or ▢No
Amnesia Afterwards (couldn't remember): ▢Yes or ▢No
Do you have any baseline concussion testing from your school or team: ▢Yes or ▢No
Are you claiming Woker's Compensation, if work related? ▢Yes or ▢No

PREVIOUS CONCUSSION HISTORY
▢ **Not Applicable**
How many have you had:
What years did they happen:
How did they occur:
Longest symptom duration: **days/weeks/years**
Pattern of less force causing concussion: ▢Yes or ▢No
Amnesia afterwards: ▢Yes or ▢No

ARE YOU BEING TREATED FOR THE FOLLOWING
History of Migraines: ▢Yes or ▢No
Learning Disability: ▢Yes or ▢No
ADHD: ▢Yes or ▢No
Developmental Delay: ▢Yes or ▢No
Anxiety/Depression: ▢Yes or ▢No
Diagnosed Sleep Disorder: ▢Yes or ▢No
School Grade:

Ascension Medical Group-Orthopaedics & Sports Medicine
CONCUSSION INTAKE FORM

Patient Name:___________________________ **Date Completed:**__________ **(AM / PM)**

Date of Injury: _______________ **Post Injury Day Number: #**________

Symptom	None 0	Mild 1	Mild 2	Moderate 3	Moderate 4	Severe 5	Severe 6
Headache							
Pressure in Head							
Neck Pain							
Nausea/Vomiting							
Dizziness							
Blurred Vision							
Balance Issues							
Light Sensitivity							
Noise Sensitivity							
Feeling Slowed Down							
Feeling “in a fog”							
Don’t Feel Right							
Difficulty Concentrating							
Difficulty Remembering							
Fatigue / Low Energy							
Confusion							
Drowsiness							
More Emotional							
Irritability							
Sadness							
Nervous / Anxious							
Trouble falling asleep							

Total Number of Symptoms	____ Of 22
Symptom Severity Score	____ Of 132
Worse with physical activity	Yes or No
Worse with mental activity	Yes or No
If 100% is feeling perfectly normal, what do % do you feel?	______ %

Ascension Medical Group-Orthopaedics & Sports Medicine
CONCUSSION INTAKE FORM

HISTORY OF PRESENTING ILLNESS

Timing of Symptoms: ▢Morning, ▢Evening, ▢Night Time, ▢None/NA

Imaging of Injury within last 2 months: ▢XR ▢Ultrasound ▢CT ▢MRI ▢MRI-Arthrogram ▢None

Physical Therapy: ▢Currently Enrolled, ▢Not Enrolled, ▢Completed Already, if so **Date:** __________

What Makes it Better: ▢Tylenol, ▢Motrin, ▢Opioid, ▢Physical Therapy, ▢Rest, ▢Ice, ▢Heat, ▢Bracing, ▢Steroid Injections, if so how many times in the past: _________, ▢None

What makes it worse: ▢Bending, ▢Squatting, ▢Stairs, ▢Running, ▢Jumping, ▢Twisting, ▢Lifting, ▢Walking, ▢Physical Therapy Exercises, ▢None/NA

GENERAL REVIEW OF SYSTEMS

Constitutional: ▢Fevers, ▢ Chills, ▢Night Sweats, ▢None

Head/Ears/Nose/Throat: ▢Migraines, ▢Nosebleeds, ▢Visual Disturbances, ▢None

Neck: ▢Swollen Glands, ▢Pain, ▢Stiffness, ▢None

Respiratory: ▢Cough, ▢Chest Pain, ▢Shortness of Breath, ▢None

Cardiovascular: ▢Chest pain, ▢Syncope, ▢Palpitations, ▢None

Gastrointestinal: ▢Nausea, ▢Vomiting, ▢Constipation, ▢Diarrhea, ▢Reflux, ▢Incontinence, ▢None

Genitourinary: ▢Urinary Frequency, ▢Burning, ▢Pain, ▢Hematuria/Blood, ▢Retention, ▢None

Hematological: ▢Anemia, ▢Low Blood Counts, ▢Bleeding Problems, ▢Blood Clots, ▢None

Dermatological: ▢Rash, ▢Bruising, ▢Abnormal Moles, ▢None

Musculoskeletal: ▢Swelling, ▢Pain, ▢Aches, ▢Deformity, ▢Decreased Range of Motion, ▢Fracture, ▢Joint Pain, ▢As per HPI, ▢None

Neurological: ▢Headaches, ▢Numbness, ▢Tingling, ▢Weakness, ▢None

PAST MEDICAL HISTORY

Check if you have history of: ▢Heart Disease, ▢Heart Attack/MI, ▢High Blood Pressure, ▢High Cholesterol, ▢Stroke, ▢TIA, ▢Epilepsy, ▢Cancer, ▢Bleeding Disorders, ▢Clotting Disorder, ▢DVT, ▢HIV/AIDS, ▢HepC, ▢Hepatitis B, ▢Anemia, ▢Diabetes, Last A1C:_____, ▢Kidney Disease, ▢Thyroid Disease, ▢Asthma, ▢COPD, ▢Pulmonary Embolism, ▢Frequent Infections, ▢Recurrent Urinary Tract Infection, ▢Depression, ▢Anxiety, ▢Eating Disorder, ▢Rheumatoid Arthritis, ▢Osteoarthritis, ▢Lupus, ▢Polio ▢Ulcerative Colitis, ▢Crohn's Disease, ▢Gastric Ulcer, ▢Migraines, ▢Fibromyalgia, ▢Other: ___________ **▢None/NA**

PAST SURGICAL & HOSPITALIZATION HISTORY

▢Denies Surgeries **▢Denies Hospitalizations** **▢Denies Admissions**

Major Surgeries: ▢Cardiac, ▢Bariatric, ▢Pulmonary (PE), ▢Neuro, ▢Abdominal, ▢DVT

Surgeries or Hospitalized/Admitted	Year (MM/DD/YYYY)	Reason for Surgery or Hospitalization	Complications (if any occurred)

Ascension Medical Group-Orthopaedics & Sports Medicine
CONCUSSION INTAKE FORM

FAMILY PAST MEDICAL HISTORY
Father: ▢Alive, ▢Deceased, ▢Unknown Father Medical History: ▢HTN, ▢HLD, ▢DM, ▢Stroke, ▢MI, ▢TIA, ▢Other, ▢None
Mother: ▢Alive, ▢Deceased, ▢Unknown Mother Medical History: ▢HTN, ▢HLD, ▢DM, ▢Stroke, ▢MI, ▢TIA, ▢Other, ▢None
Sibling: ▢Alive, ▢Deceased, ▢Unknown Sibling Medical History: ▢HTN, ▢HLD, ▢DM, ▢Stroke, ▢MI, ▢TIA, ▢Other, ▢None
Maternal Grandmother: ▢Alive, ▢Deceased, ▢Unknown Past Medical History: ▢HTN, ▢HLD, ▢DM, ▢Stroke, ▢MI, ▢TIA, ▢Other, ▢None
Maternal Grandfather ▢Alive, ▢Deceased, ▢Unknown Medical History: ▢HTN, ▢HLD, ▢DM, ▢Stroke, ▢MI, ▢TIA, ▢Other, ▢None
Paternal Grandmother: ▢Alive, ▢Deceased, ▢Unknown Past Medical History: ▢HTN, ▢HLD, ▢DM, ▢Stroke, ▢MI, ▢TIA, ▢Other, ▢None
Paternal Grandfather ▢Alive, ▢Deceased, ▢Unknown Medical History: ▢HTN, ▢HLD, ▢DM, ▢Stroke, ▢MI, ▢TIA, ▢Other, ▢None

SOCIAL HISTORY
Work History: ▢Employed, ▢Unemployed, ▢N/A
Current/Previous Occupation if applicable: ▢N/A
If off work, date you last worked: ▢N/A
Do you Live Alone: ▢Yes, ▢No, ▢N/A **Can you care for yourself at home:**▢Yes, ▢No, ▢N/A
Are you housebound: ▢Yes, ▢No
Can you complete activities of daily living unassisted, (eat, bathe, dress, groceries): ▢Yes, ▢No
Can you do heavy/strenuous activities (moving furniture, shoveling snow, mowing grass):▢Yes ▢No
Do you have children: ▢Yes, ▢No, ▢N/A **How many:**
Type of exercise you do or sports played: ▢Running, ▢Elliptical, ▢Rower, ▢Bike, ▢Weight Lifting ▢Recreational Gym, ▢Golf, ▢Organized Sports (▢Football, ▢Soccer, ▢Hockey, ▢XC, ▢VB, ▢Baseball, ▢Softball, ▢Track, ▢Basketball, ▢Wrestling, ▢Swim, ▢Dance ▢Golf), ▢None
Special Diet: ▢Yes, ▢No, ▢N/A , **If So Describe:**
Do you live in a threatening environment: ▢Yes, ▢No, ▢N/A, **If Yes Explain:**
Do you have history of abuse: ▢Yes, ▢No, ▢N/A, **If Yes Explain:**
Do you currently Smoke: ▢Yes, ▢No, ▢N/A, **Frequency:**
If you smoke or used to, How many packs per day: _______ **and for how long:** __________
Do you Chew, Dip, Rub, or Use E-Cigarette: ▢Yes, ▢No, ▢N/A, ▢Chew, ▢Dip, ▢Rub, ▢E-cigarette
Alcohol Consumption: (Wine, Beer, Liquor): ▢Daily, ▢1-2 per week, ▢1-2 per month, ▢1-2 per year, ▢socially/holidays, ▢Never/NA
Any problems with reading or eye sight: ▢Yes, ▢No, **If Yes Explain:**
Any hearing problems: ▢Yes, ▢No, **If Yes Explain:**
Illicit Drug Use: ▢Yes, ▢No, ▢N/A, **If Yes Explain:**
Controlled Substance agreement with PCP or Pain Clinic: ▢Yes, ▢No, ▢N/A
If on an agreement please elaborate (what medication, for what condition, and for how long):

Ascension Medical Group-Orthopaedics & Sports Medicine
CONCUSSION INTAKE FORM

ALLERGIES
Medication Allergy: ▢Yes, ▢No, **If Yes what medication and what happens:**
Metal Allergy: ▢Yes, ▢No, **If Yes what medication and what happens:**
Seasonal Allergy: ▢Yes, ▢No, **If Yes Explain:**

MEDICATIONS
Are you on Blood thinners: ▢Yes, ▢No, ▢N/A, **If Yes Explain:**
Examples of Blood Thinners/Antiplatelets: ▢Aspirin, ▢Coumadin/Warfarin, ▢Eliquis, ▢Xarelto, ▢Heparin, ▢Lovenox, ▢Arixtra, ▢Plavix, ▢Pradaxa, ▢Effient, ▢Brilinta
Controlled Substances: ▢Norco, ▢Vicodin, ▢Morphine, ▢Fentanyl, ▢Dilaudid, ▢Percocet
▢Ambien, ▢Gabapentin, ▢Lyrica, ▢Tramadol, ▢Xanax, ▢Amphetamines
List all your medications to the best of your ability: