If this was a sport related concussion, please complete 1-7 below:

1. Sport: ___________________________
2. School: ___________________________
3. Athletic Trainer or School Nurse: ___________________________
4. Baseline ImPACT Test?  Yes  No
   (Bring baseline and most recent score to 1st appointment)
5. Average Academic Performance
   A+  A  B+  B  C+  C
6. Athletic Trainer or School Nurse: ___________________________
7. Who do you live with?
   ☐ One-Parent
   ☐ Two-Parent
   ☐ Other (specify who: grandparent, friend, etc ___________________________

Tell us about your most recent concussion:

1. When did it occur? _________________________________________
2. How did it happen? (sport, fall, assault, MVA) ____________________________________________________________________
   ____________________________________________________________________
3. Circle the symptoms you had at the time of the injury:
   Loss of consciousness (how long? _______)  Amnesia  Confusion  Headache  Dizziness
   Other ___________________________
4. Did you go a hospital or urgent care for your injury?  Yes  No  If yes, when? ___________________________
5. Have you had any of the following imaging tests since your injury?
   Head CT  Head MRI  Neck x-rays  Neck CT  No Imaging
6. Is there current legal action involved in your concussion?  Yes  No
7. List the dates you were unable to play your sport due to your injury: (disregard if not playing sport) ____________________________________________________________________
   ____________________________________________________________________

[Continued on next page]

8. List the dates you were unable to attend school or work due to your injury: ____________________________________________________________________
   ____________________________________________________________________
9. Which symptoms or problems have been bothering you the most since your concussion?:
____________________________________________________________________________
____________________________________________________________________________

10. What medications or therapies have you used to treat your concussion symptoms?
____________________________________________________________________________
____________________________________________________________________________

Prior Concussion History:
Number of previous concussions: _________
Dates of prior concussions: _____________________________________________________

Current Medications  □ None
List all medications you are currently taking including herbs, vitamins, or supplements

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
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Medical History  □ None
List all past and current medical problems (ex: asthma) and surgeries (ex: ACL repair)

<table>
<thead>
<tr>
<th>Medical Problem</th>
<th>Surgeries</th>
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</table>

Do you use or have you ever used:

Alcohol   Y   N          Drinks per week ______________
Marijuana Y   N
Nicotine products/Tobacco Y   N

Please circle Personal History (PH), Family History (FH), or None (N)

History of headache(s)   PH   FH   N
History of migraine(s)   PH   FH   N
History of neurodegenerative disease (Alzheimer’s, Parkinson’s)   PH   FH   N
Anxiety   PH   FH   N
Depression   PH   FH   N
Sleeping Disorder   PH   FH   N

Developmental Delay   PH   FH   N
Sensory Integration Disorder   PH   FH   N
Processing Disorder   PH   FH   N
Dyslexia   PH   FH   N
ADHD / ADD   PH   FH   N
Strabismus   PH   FH   N
Lazy Eye   PH   FH   N
Motion Sensitivity/Car Sickness   PH   FH   N
Brain/Spine Tumor   PH   FH   N
Brain/Spine Infection   PH   FH   N