STAMFORD HEALTH
Healing. Reimagined.

# CONCUSSION CENTER
## Medical History, Post-Injury

Occupation (please indicate full/part time)_____

If student please indicate current school/grade _____

How did you hear about us?_____ Pediatrician / PCP _____

Primary language _____ Secondary language if applicable _____

**Current injury date** (Estimate if unsure)_____

How did the injury occur? ☐ Sports ☐ Fall ☐ MVA ☐ Assault ☐ Other

Injury Description

_____

_____

_____

Did you seek immediate medical care? ☐ Yes ☐ No If yes, when? (Date) _____ Where?_____

Did you have any brain scans/imaging? ☐ Yes ☐ No If yes, what type? ☐ CT ☐ MRI ☐ Unsure

Do you know the results? ☐ Yes ☐ No Details _____

**Please select the symptoms you experienced within the first 3 days of your injury.**

| | | |
|---|---|---|
| ☐ Headaches | ☐ Sensitivity to light/noise | ☐ Nausea |
| ☐ Neck pain | ☐ Trouble moving arms/legs | ☐ Vomiting |
| ☐ Numbness/Tingling | ☐ Dizziness | ☐ Balance problems |
| ☐ Attention/Concentration problems | ☐ Blurred/Double/Loss of vision | ☐ Slowed thinking |
| ☐ Memory problems | ☐ Feeling "foggy" | ☐ Feeling more emotional |
| ☐ Trouble sleeping/Sleeping too much | ☐ Feeling drowsy | ☐ Irritability |
| ☐ Sadness | ☐ Anxiety/Stress | ☐ Tiredness |

Please list any other symptoms you have experienced _____

_____

How many days of school/work have you missed since your injury?_____

List any sports, dance, gym, or activities you regularly engage in _____

_____

Have you ever taken a computerized test for concussion and/or baseline? ☐ Yes ☐ No Date of most recent test _____

Location of most recent baseline (school/MD office, etc.) _____

Was it ImPACT? **If yes**, Passport ID # (if known)_____

**Personal and Family History**

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Current medications _____

_____

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**Have you ever been diagnosed with a concussion *Prior* to this injury?** ☐ Yes ☐ No If yes, estimated number _____

| Month/Year (approximate) | Age | How it occurred (brief description) | Approximate time to recover (i.e., few days, 1 week, 3 months) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| PRIOR to your current injury, was there a history of: | Personal History Yes | Personal History No | Family History* Yes | Family History* No | *If "Yes" to family history, please indicate maternal, paternal, both, sibling, unknown |
|---|---|---|---|---|---|
| Headaches (migraine, tension, etc.) | ☐ | ☐ | ☐ | ☐ | |
| Visual conditions (lazy eye, strabismus, nystagmus) | ☐ | ☐ | ☐ | ☐ | |
| Motion sickness/Vertigo | ☐ | ☐ | ☐ | ☐ | |
| Seizure disorder/Epilepsy | ☐ | ☐ | ☐ | ☐ | |
| Depression/Anxiety | ☐ | ☐ | ☐ | ☐ | |
| Dementia (Alzheimer's, Parkinson's, etc.) | ☐ | ☐ | ☐ | ☐ | |
| Multiple Sclerosis or other neurological conditions | ☐ | ☐ | ☐ | ☐ | |
| Substance abuse/dependence | ☐ | ☐ | ☐ | ☐ | |
| Attention Deficit/Hyperactivity Disorder (ADHD) | ☐ | ☐ | ☐ | ☐ | |
| Learning disability | ☐ | ☐ | ☐ | ☐ | |
| Autism/Spectrum Disorder/Developmental Disorder | ☐ | ☐ | ☐ | ☐ | |

**For personal history ONLY:** Please explain any YES answers above (i.e., treatment, age onset, etc.)

_____

_____

Do you wear prescription lenses? ☐ Yes ☐ No If yes, what type? ☐ Distance ☐ Reading ☐ Both

Please list any other significant medical conditions _____

_____

Number of years of education/schooling completed? (i.e., HS=12 / College=16) _____

Highest grade completed and/or degree obtained _____

What kind of grades do/did you receive in school? ☐ Average ☐ Above average ☐ Below average

Have you had accommodations or additional services? (i.e., Speech therapy, 504 Plan, IEP, etc.) ☐ Yes ☐ No

If Yes, please provide brief description _____

| Name of Person Completing Form | Relationship | Time (am / pm) | Date |
|---|---|---|---|
| | | | |