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PEDIATRIC NEUROLOGY - MEDICAL HISTORY INTAKE - NEW PATIENT CONCUSSION/ HEAD INJURY

*PATIENT NAME:*_____ *DOB:*_____/_____/_____

*PARENT/GUARDIAN NAME:*_____

The following questions relate to your general health. The details of this form will only be reviewed by your physician and nurse.

Referred for Evaluation by:_____

Preferred Pharmacy: (name and location)_____

CURRENT SYMPTOMS:

1._____

2._____

3._____

CHRONIC MEDICAL PROBLEMS: ☐ None, healthy

1. _____

2. _____

3. _____

MEDICATION: ☐ No Medications

1._____ Dosage:_____# of Times a day_____

Reason for medication:_____

2._____ Dosage:_____# of Times a day_____

Reason for medication:_____

3._____ Dosage:_____# of Times a day_____

Reason for medication:_____

ALLERGIES: ☐ No Allergies

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

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HEAD INJURY SYMPTOMS:

Date of Injury:_____

How did the injury occur:_____

Describe injury: (hit to the head, to the body, twisting of the neck, etc)_____

_____

Helmet use during injury: (circle please) Y N

Location of injury (on body): (Circle please)
Frontal Side: R L Back Neck Face

Location of pain (circle please):
None Face Head Neck

Quality of the pain (circle please):
Aching Burning Dull Sharp Throbbing Stabbing
Constant Intermittent Other: _____

Risk factors (circle please):
Alcohol: Y N Recreational drugs: Y N Prescribed medications: Y N
Fractures (broken bones): Y N If in car: seat belt: Y N

What make symptoms worse? (Circle please)
Bending over Caffeine Exercise/Exertion Light Sound
Lying down Pressure Sitting up Smells Touch
Bearing down (cough/stooling)
Others? _____

What make symptoms better? (Circle please)
Medications _____
Cold compresses Heat Rest Sleep Nothing
Others? _____

Associated symptoms: (Circle please)

Bleeding from ears	Headache	Memory difficulties	Restlessness
Bruising around eyes	Hearing loss	Nausea	Seizures
Clumsiness	Incoordination	Smell disturbance	Sleepiness
Confusion	Increased thirst	Weakness	Speech change
Ear leakage	Irritable	Personality change	Stiff neck
Nose leakage	Consciousness loss	Increased need to pee	Behaviors
Bloody nose	Numbness	Projectile vomiting	Vision change
Fever	Lucidity	Prolonged loss of consciousness (>15 mins)	
Gait change	Homework time increased		

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MED/SURG/INTERIM History (Hospitalizations, ER visits, and Surgeries)

Hospital stays:

1. Reason:_____ Dates:_____

2. Reason:_____ Dates:_____

ER visits:

1. Reason:_____ Date:_____

Reason:_____ Date:_____

Surgeries:

1. Reason:_____ Date:_____

2. Reason:_____ Date:_____

DIAGNOSTIC TESTS:

☐ CT head: ___/___/___ ☐ MRI brain:___/___/___ ☐ MRA/MRV:___/___/___

☐ EEG:___/___/___ ☐ EMG:___/___/___ ☐ Other: _____

FAMILY MEDICAL HISTORY:

Mother: _____

Father: _____

Siblings: _____

_____

OTHER: (grandparents/aunts/uncles/cousins): In particular, any cerebral palsy, muscle weakness/ dystrophies, strokes in young (<55years old), autism, developmental delays, birth defects, multiple sclerosis, sudden unexplained deaths, and other illnesses that you know of?

_____

_____

_____

SOCIAL HISTORY:

Who lives in the house?_____

Any pets?_____

Who smokes in the family (including patient if patient smokes)?_____

Services? (PT/OT/speech)_____

Grade in school:_____ Grades:_____ Accommodations:_____

Extracurricular activities:_____

What do you want to be when you grow up?_____

Mother's occupation:_____

Father's occupation:_____

Any special spiritual/religious needs?_____

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Is the patient experiencing any of the following? Phase mark Yes or No to each symptom.

CONSTITUTIONAL			GASTROINTESTINAL			NEUROLOGICAL		
No	Yes		No	Yes		No	Yes	
		Chills			Abdominal pain			Appropriate interaction
		Decreased Activity			Constipation			Behavioral changes
		Decreased Appetite			Diarrhea			Consolable
		Fever			Nausea			Difficulty concentrating
		Fussiness			Reflux			Distorted body image
		Irritability			Vomiting			Self conscious
		Lethargy						Aphasia
		Weight gain						Dizziness
		Weight loss						Speech disorder
HEENT			GENITOURINARY					Focal weakness
No	Yes		No	Yes				Gait disturbance
		Difficulty swallowing			Decreased urine output			Headache
		Ear discharge			Painful urination			Incontinence
		Crossed eye			Unable to control urination			Incoordination
		Eye discharge			Flank pain			Light-headedness
		Eye redness			Foul urine odor			Loss of consciousness
		Headache			Blood in urine			Memory impairment
		Hearing loss	REPRODUCTIVE FEMALE					Near syncope
		Nasal congestion	No	Yes	Painful periods			Paresthesia
		Ear pain			Heavy period			Seizures
		Sore throat			Vaginal discharge			Speech changes
		Nasal drainage			Vaginal itching			Tremors
		Sneezing						Vertigo
		Tearing						Visual Changes

RESPIRATORY			REPRODUCTIVE MALE			PSYCHIATRIC		
No	Yes		No	Yes		No	Yes	
		Difficult breathing			Circumcised			Appropriate interaction
		Wheezing			Penile discharge			Consolability
		Use of accessory muscles			Scrotum, testicular mass			Difficulty concentrating
		Cough			Scrotum testicular pain			Psychiatric/emotional
		Known exposure to Tb	METABOLIC ENDOCRINE			MUSCULOSKELETAL		
		Sputum						
CARDIOVASCULAR			No	Yes		No	Yes	
No	Yes				Excessive thirst			Bone pain
		Chest pain			Polyuria (voiding a lot)			Joint pain
		Irregular heartbeat	VASCULAR					Joint swelling
		Syncope/fainting						Muscle weakness
Heart murmur			No	Yes				Muscle pain
		Structural defect			Cool extremity			
		Palpitations			Rash			
HEMATOLOGIC			IMMUNOLOGICAL					
No	Yes		No	Yes				
		Easy bleeding			Allergic rhinitis			
		Easy bruising			Environmental, allergies			
		Swollen glands			Food Allergies			

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SCAT 2

Sport Concussion Assessment Tool 2

Name_____

Sport/team_____

Date/time of injury_____

Date/time of assessment_____

Age_____ Gender ☐ M ☐ F

Years of education completed_____

Examiner_____

What is the SCAT2?[1]

This tool represents a standardized method of evaluating injured athletes for concussion and can be used in athletes aged from 10 years and older. It supersedes the original SCAT published in 20 052. This tool also enables the calculation of the Standardized Assessment of Concussion (SAC)[3,4] score and the Maddocks questions[5] for sideline concussion assessment.

Instructions for using the SCAT2

The SCAT2 is designed for the use of medical and health professionals. Preseason baseline testing with the SCAT2 can be helpful for interpreting post-injury test scores. Words in italics throughout the SCAT2 are the instructions given to the athlete by the tester.

This tool may be freely copied for distribution to individuals, teams, groups and organizations.

What is a concussion?

A concussion is a disturbance in brain function caused by a direct or indirect force to the head, it results in a variety of non-specific symptoms (like those listed below) and often does not involve loss of consciousness. Concussion should be suspected in the presence of any one or more of the following:

- Symptoms (such as headache), or
- Physical signs (such as unsteadiness), or
- Impaired brain function (e.g. confusion) or
- Abnormal behaviour.

Any athlete with a suspected concussion should be REMOVED FROM PLAY, medically assessed, monitored for deterioration (i.e., should not be left alone) and should not drive a motor vehicle.

Symptom Evaluation

How do you feel?

You should score yourself on the following symptoms, based on how you feel now.

	none	mild		moderate			severe
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep (if applicable)	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

Total number of symptoms (Maximum possible 22)

Symptom severity score

(Add all scores in table, maximum possible: 22 x 6 = 132)

Do the symptoms get worse with physical activity? ☐ Y ☐ N

Do the symptoms get worse with mental activity? ☐ Y ☐ N

Overall rating

If you know the athlete well prior to the injury, how different is the athlete acting compared to his/her usual self? Please circle one response.

no different **very different** **unsure**

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