Banner Health®

CONCUSSION PATIENT INFORMATION

If you are unsure of a question or do not feel well enough to complete this form you may leave it blank and ask for assistance from the medical assistant when you are called back. Thank you.

Name: _____ **Today's Date:** _____

D.O.B.: _____ **Age:** _____ **Gender:** _____ **Sport:** _____ **School:** _____

Primary Reason(s) for Today's Visit: **Date of Injury:** _____

_____

How were you referred to our center (please be specific)?: _____

Were you seen in the hospital/ER or have imaging performed as a result of this injury (please list where and when)?:

_____

Was this injury the result of a motor vehicle accident?: _____

Please list your preferred pharmacy (name, address, phone #):

_____

Are you experiencing any of the following symptoms?: ❑ No

❑ Chills	❑ Headache	❑ Back Pain
❑ Fatigue	❑ Memory Loss	❑ Joint Pain
❑ Fever	❑ Seizures	❑ Muscle Weakness
❑ Vision Loss	❑ Anxiety	❑ Neck Weakness
❑ Nausea	❑ Depression	❑ Neck Pain
❑ Vomiting	❑ Insomnia	❑ Contusion
❑ Dizziness	❑ Laceration / Abrasion	

Allergies: (Drug or Non Drug Related) ❑ Unknown ❑ See List

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

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Current Medications (Including Birth Control Pills, Vitamins, Supplements, and Inhalers): ❑ None

1. _____ Dosage: _____ Frequency: _____
2. _____ Dosage: _____ Frequency: _____
3. _____ Dosage: _____ Frequency: _____
4. _____ Dosage: _____ Frequency: _____

Chronic Illness: ❑ None (Please include the year diagnosed)

❑ Anemia _____
❑ Atrial Fibrillation _____
❑ Arthritis _____
❑ Asthma _____
❑ Anxiety _____
❑ Blood Clots _____
❑ Cancer _____
❑ COPD _____
❑ Depression _____
❑ Diabetes _____
❑ High Blood Pressure _____
❑ Hepatitis A, B, C _____
❑ Heart Attack _____
❑ Insomnia _____
❑ Migraines _____
❑ Osteoporosis _____
❑ Seasonal Allergies _____
❑ Seizures _____
❑ Thyroid Disease _____

Surgical History: ❑ None ❑ See List

1. _____ Year: _____
2. _____ Year: _____
3. _____ Year: _____

Family History: Has anyone in your **immediate** family been diagnosed with any of the following? ❑ No
(Please include family relation)

❑ ADD / ADHD / Dyslexia _____
❑ Anemia _____
❑ Arthritis _____
❑ Asthma _____
❑ Anxiety _____
❑ Atrial Fibrillation _____
❑ Blood Clots _____
❑ Cancer _____
❑ COPD _____
❑ Depression _____
❑ Diabetes _____
❑ Heart Attack _____
❑ Hepatitis A, B, C _____
❑ High Blood Pressure _____
❑ Insomnia _____
❑ Migraines _____
❑ Osteoporosis _____
❑ Seasonal Allergies _____
❑ Seizures _____
❑ Thyroid Disease _____
❑ Alzheimer's Disease _____

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Social History:

Marital Status: ❑ Married ❑ Single ❑ Divorced Occupation: _____ ❑ Retired ❑ Student _____

Do you Exercise? ❑ No ❑ Yes, please list type and frequency: _____

Do you smoke and/or use tobacco? ❑ No ❑ Former ❑ Yes, type: _____

Do you drink alcohol? ❑ No ❑ Former ❑ Yes, amount: _____

Do you consume caffeine? ❑ No ❑ Yes, please list type and quantity: _____

Do you use any illicit drugs? ❑ No ❑ Yes, please list type and quantity: _____

Concussion History:

Have you ever been diagnosed with a head injury or concussion in the past? ❑ No ❑ Yes
(Please lest the year and details of each injury including symptoms, duration, imaging, and treatment):

Year / Symptoms	Duration	Imaging (CT, MRI, X-Ray)	Treatment
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Do you get car sick? ❑ No ❑ Yes ❑ Sometimes

Have you ever been diagnosed with a learning disability such as ADD, ADHD, and/or Dyslexia? ❑ No
(Please include date diagnosed, past/current treatment, and the Doctor who diagnosed. _____

_____

Dizziness:

Are you experiencing symptoms of vertigo (spinning sensation)? ❑ No ❑ Yes

If yes, how long does the spinning last? ❑ Less than 1 minute ❑ 2-5 minutes ❑ 5 or more minutes

Are you experiencing symptoms of dizziness (fogginess and/or difficulty focusing)? ❑ No ❑ Yes

Are you feeling off balance? ❑ No ❑ Yes

Vision:

Do your eyes feel tired when reading or doing close work? ❑ No ❑ Yes

Do you notice the work blurring or coming in and out of focus when reading or doing close work? ❑ No ❑ Yes

Do you have blurred vision at far distance? ❑ No ❑ Yes

Do you cover or close one eye to see well? ❑ No ❑ Yes

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