Today's Date: _____

CONCUSSION HISTORY FORM

Client's Name: _____ DOB: _____/_____/_____

Age: ____Grade: ____ School: _____ City/District: _____

Parent(s) Name completing form: _____Email: _____ Phone: (_____)_____

Address: _____ City: _____ Zip: _____

Referred by: _____Specialty: _____Phone: (_____)_____

Concussion History

Recent Injury

Date of injury: _____ Cause: ☐ Fall ☐ Assault ☐ Sports _____ ☐ Other_____

Please describe any additional relevant details related to your child's recent injury:

Is your child currently experiencing symptoms? ☐ Yes ☐ No

Check all *current* symptoms (within the last week):

☐ Headaches	☐ Light sensitivity	☐ Irritability
☐ Fatigue	☐ Noise sensitivity	☐ More emotional
☐ Visual problems	☐ Dizziness	☐ Drowsiness
☐ Nausea	☐ Problems with concentration	☐ Sleep disruption
☐ Balance problems	☐ Appears more slowed down	☐ Other symptom (s):

Is your child experiencing school difficulties as a result of his/her recent injury? ☐ Yes ☐ No

Describe:

Has your child's academic performance been affected by his/her injury? ☐ Yes ☐ No

Describe:

Is your child receiving any academic supports because of his/her injury? ☐ Yes ☐ No

If yes, list supports:

Please list the names and contact information of all providers (if different than referral source) *currently* seeing your child related to his/her injury:

Name	Phone
_____	_____
_____	_____

Prior Concussion History

Has your child had prior concussions? ☐ Yes ☐ No

If yes, provide the following details:

Date or Year	Cause	Fully recovered from injury?
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

Additional relevant details related to your child's concussion history can be described here:

Background History

Medical History

Has your child experienced any of the following conditions? If yes, please describe (include medications)

History of headaches ☐ Yes ☐ No
(note if migraines and if medicated)

Vision Problems ☐ Yes ☐ No

Use of Glasses or Contacts ☐ Yes ☐ No

ADHD ☐ Yes ☐ No

Anxiety, depression or other mood difficulties ☐ Yes ☐ No

Other medical history ☐ Yes ☐ No

Please list all medications that your child is currently taking (including over the counter medications). Please include purpose & dosage of each.

Medication and Purpose	Dose and Frequency
_____	_____
_____	_____
_____	_____

Educational History

Please indicate whether your child has received or experienced any of the following prior to his/her injury:

- ☐ Learning difficulties If yes, describe:
- ☐ Poor grades If yes, describe:
- ☐ Speech Therapy If yes, describe:
- ☐ Occupational Therapy If yes, describe:
- ☐ Vision Therapy If yes, describe:
- ☐ IEP If yes, describe:
- ☐ 504 Plan If yes, describe: