SAINT PETER'S
SPORTS MEDICINE INSTITUTE
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

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PATIENT LABEL

Concussion Intake Form

Name of child (printed): _____ Age: _____ Child DOB: _____

Name of parent/guardian filling out form (printed): _____ Relationship to Child _____

Today's Date _____ Date you sustained the concussion _____

Please describe how your injury occurred and the location on the head or body (if force transmitted to the head)

_____

_____

Please circle the symptoms that you had immediately after the injury:

Headache	Vision Changes	Dizziness	Balance Problems
Nausea	Vomiting	Ringing in the Ears	Personality Changes
Disoriented	Felt like you had your bell rung or been dinged		Confused about Events

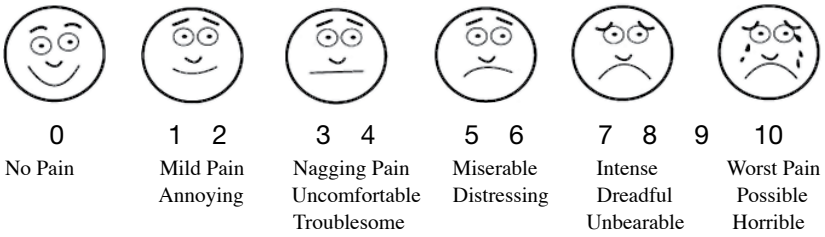
Loss of Consciousness (How long? _____)

Do not remember events just BEFORE the injury (How long? _____)

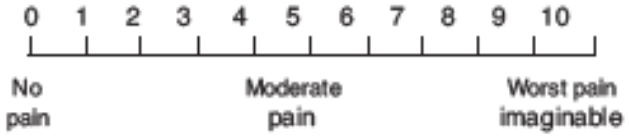
Do not remember events just AFTER the injury (How long? _____)

Is there pain? **Yes** **No** (if No, skip next 2 questions)

For the next 2 questions: (younger patients: parents please refer to the faces below, older patients please rate you pain on a scale of 0-10)



0	1 2	3 4	5 6	7 8 9	10
No Pain	Mild Pain Annoying	Nagging Pain Uncomfortable Troublesome	Miserable Distressing	Intense Dreadful Unbearable	Worst Pain Possible Horrible



What was the level of pain when it first started: 0 1 2 3 4 5 6 7 8 9 10

And what is the level of pain now: 0 1 2 3 4 5 6 7 8 9 10

Have you seen any other physicians/clinicians for this problem? (if yes, please explain)

_____

_____

Have you taken any medications for the pain? (if yes, please list)

_____

How many concussions have you had in the past? 0 1 2 3 4 5 6+

If you have sustained a concussion in the past, please provide the date of injury, how the injury occurred, initial symptoms (was there loss of consciousness, amnesia, or confusion/disorientation), duration of symptoms, and how long it took for you to return to sports after the injury.

Prior Concussions: _____

_____

_____

For this problem, please list any studies ordered:

-X-rays: area of body _____ date_____ location _____

-CT Scan: area of body _____ date_____ location _____

-MRI Scan: area of body _____ date_____ location _____

-Blood work: date_____ location _____

Patient Medical History - *Does your child have:*	Yes	No	Comments
1. Congenital heart defects and/or murmurs			
2. Seizures/Epilepsy			
3. Meningitis			
4. Migraines/Frequent headaches			
5. Neurologic deficits			
6. Nearsightedness/Farsightedness /Astigmatism			
7. Strabismus/Amblyopia (Lazy eye)			
8. History of vision therapy			
9. Car (motion) sickness			
10. History of speech therapy/reading therapy			
11. History of special education/504 plan/IEP			
12. Depression/Anxiety/Bipolar			
13. Learning disorder/ADHD/dyslexia			
14. Asthma			
15. Cancer/blood disorders/anemia			
16. Diabetes			
17. Rheumatoid arthritis			
18. Thyroid problems			
19. Sleep Apnea/Snoring/Sleep disorder			
20. Gastric reflux/GERD			

Family History: *Has anyone in your immediate family ever been treated for any of the following:*	Yes	No	Relative
1. Diabetes			
2. Heart disease			
3. High blood pressure			
4. Cancer			
5. Osteoporosis or metabolic bone disease			
6. Rheumatoid arthritis/Lupus/other inflammatory disorders			
7. Mental illness/Depression/Anxiety			
8. Bleeding disorders			
9. Neurologic disorders/Migraines			
10. Asthma/Reactive Airway disease			
11. Unexplained sudden death			
12. Alcohol/drug dependency			

Current Health *Have you noticed any of the following symptoms in your child or does your child complain of:*	Yes	No	Comments
1. Constitutional: Unexplained weight loss/gain, fever, chills, sweats, fatigue			
2. Eyes: Glasses/contacts, blurred/double vision			
3. ENT: Ringing in ears/hearing problems			
4. CV: chest pain/heart palpitations			
5. Respiratory: shortness of breath/ cough/wheezing			
6. GI: nausea/vomiting/heartburn			
7. GU: bowel/urinary problems			
8. Mskl: Joint/bone pain			
9. Neurologic: numbness/tingling/ dizziness/balance problems			
10. Psychiatric: Depression/ anxiety/nervousness			
11. Hematologic: Easy bleeding/bruising			
12. Skin: Skin problems			
13. Other			

Allergy History:

Drug allergies: ❑ None Known ❑ Yes (Please list your child's allergies and the reaction) _____

Latex Allergies: ❑ Yes ❑ No (If yes, what is the reaction) _____

Medications:
List any medications you are currently taking (prescription, over the counter, and vitamins): _____

_____

Past Surgeries: Please list all surgeries and what year surgery was performed: _____

_____

Prior Hospitalizations: ❑ Yes ❑ No (If yes, what was the reason for the hospitalization and what year): _____

_____

Social History

School _____ Grade _____
Performance in school (circle one): Above Average Average Below Average
What sports/activities does the patient participate in? ❑ None (or specifiy below)

_____
Please list of all your classes: _____
Do you exercise regularly? ❑ Yes ❑ No (If yes, how many hours per week): _____
Which best describes the patient's living arrangements? (check all that apply)
❑ Lives with both biological parents
❑ Lives with one parent/guardian (circle one) (mother, father, grandparent, other)
• Specify who is the legal guardian (mother, father, other) _____
❑ Lives with adoptive parents ❑ Other (please explain) _____
Please indicate parent(s)/guardian(s) occupation: _____
Does the patient smoke? **YES NO** (circle one) Do any other members in the household smoke? **YES NO** (circle one)
Do you or your child have a need to discuss any emotional or physical harm that you or your child may be experiencing?

_____
Do you ever feel unsafe at home or has anyone hit your child or tried to injure your child? _____

Patient Signature or Parent/Legal Guardian _____ Date: _____ Time: _____

Reviewed by: _____ Date: _____ Time: _____