THE CONCUSSION GROUP

Patient History

This form is to be filled out by the patient. If assistance is needed, please list representation: _____
(first & last name)

Patient Name: _____ **Date of Birth:** _____ **Gender:**_____

Date of Injury _____/_____/_____ **Type of Injury** (describe briefly) _____
(month / date / year)

Was there loss of consciousness? ☐ **No** ☐ **Yes** (if so, how long?) _____

Did patient go to the hospital? ☐ **No** ☐ **Yes** (if so, how long?)_____

Did patient require stitches or head/brain surgery? ☐ **No** ☐ **Yes** (describe) _____

Please check all the symptoms that apply:

☐ Headaches ☐ Dizziness / Vertigo ☐ Confusion / Dazed ☐ Nausea / Vomiting

☐ Hearing Loss (right / left) ☐ Vision Loss (right / left) ☐ Weakness (right / left) ☐ Numbness (right / left)

☐ Slurred Speech ☐ Personality changes ☐ "Don't feel right" ☐ Others note behavior changes

☐ Depression ☐ Fatigue ☐ Sleeplessness ☐ Difficulty at work / school

☐ Seizures ☐ Memory Problems / Forgetfulness (describe)

Please check all the conditions that apply:

☐ TIA / Stroke ☐ Brain Tumor ☐ ADD / ADHD ☐ Alcohol Abuse History

☐ Drug Abuse History ☐ Boxing or Team Sport History (describe)

Has patient ever had cancer chemotherapy? ☐ **No** ☐ **Yes** (if so, list approximate dates)

Is there any past history of head trauma? ☐ **No** ☐ **Yes** (if so, when & please provide a brief description)

Has patient had any previous CT or MRI studies of the brain? ☐ **No** ☐ **Yes** (if so, where and when)

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions.

_____ _____

Patient Signature (or parent/guardian) ***Date Signed***

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