

CSG Sports Medicine: Concussion History

Head Injury History: (To be completed by the patient and parent)

Prior to this injury, have you EVER had a concussion ("bell rung") as a result of a head injury?

Yes / No

If yes, previous number (excluding the current injury) 0 1 2 3 4 5+

What was the date of your current head injury _____

How did the head injury occur? _____

Did you lose consciousness? Yes / No If yes, for how long? _____

Were you told you had a concussion? Yes / No If yes, who told you this? _____

Have you been seen by your primary care provider or the emergency room for this injury?

Yes / No - If so, who did you see and when? _____

What tests have been done? (x-rays, CT, MRI, etc) _____

When and where were these tests done? _____

What symptoms did you have immediately after your injury? _____

What symptoms do you have now? _____

What symptoms bother you the most? _____

What medications/treatments have you used? _____

Have you been diagnosed or told you may have:

ADHD / ADD?

Migraines?

Depression, anxiety or other psychiatric diagnosis?

Learning disability?

Have you ever repeated one or more years of school?

Seizure disorder?

None of the above

_____ Date ___/___/___ Time _____

Attending Physician Signature