Physical Therapy &
Vestibular Rehabilitation

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Adult Concussion Medical History Form

Patient Name:_____ Date of Birth:_____

Reporter: ___Patient ___Spouse ___Other:_____

Height:____Ft____in Weight:_____lb

In order for us to help you recover from your brain injury it is important to know as much as we can about how you were injured and what problems you've had since your injury. The questions below will help us to treat your concussion.

1. What is the date of your most recent concussion? _____
2. Was this work related? Yes No If yes, is there litigation? _____
3. Work status: full time ____ part time ____
4. Describe the event that caused the concussion._____
   _____
5. Did you miss work due to your concussion? _____

If concussion is unrelated to sport, please skip to question 12.

6. Which sport/activity were you participating in? _____
7. If sport related, what position were you playing at the time? _____
8. Did you continue to play after the injury? Yes No If yes, how long did you play for?
9. Were you wearing a helmet when you fell? Yes No
10. Have you continued to exercise since your injury? Yes No
11. Did your injury occur during: Practice Game Other:_____
12. Did you lose consciousness (get knocked out) at the time of your concussion? Yes No
13. If **yes**, for how long, approximately, were you unconscious? *(circle one)*
14. <1 minute 1-5 minutes 5-10 minutes >10 minutes
15. Have you lost your memory of events which occurred **before** your concussion? Yes No
16. Have you lost your memory of events which occurred **after** your concussion? Yes No
17. Did you have any neck pain following your injury? Yes No

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18. How many concussions have you had in the past? 0 1 2 3 4 5 6 7 8 9 10 >10

19. During which activity did you sustain your previous concussion(s)?

20. **Have you had change in Mood since the concussion?** Yes No_____

21. **Have you have trouble with sleeping well?_____Headache_____Dizziness_____**

Past Medical History: *(check all that apply)*

___Attention deficit hyperactivity disorder (ADHD)	___Depression	___Heart disease
___Seizures	___Anxiety	___Lung disease
___Frequent headaches	___Diabetes	___Obesity
___Dyslexia	___Dizziness	___Osteoporosis/osteopenia
___Motion sickness (ex. Car or plane rides)	___Noise in ears	___Smoker
___A learning disability	___Double vision	___Take Steroids
___Hypertension	___Currently Pregnant	___Cancer
___Bowel or bladder difficulties	___Migraines/family history of migraine	
___Circulatory Disorders		

Restless_____ Difficulty falling asleep_____Sleeping too much_____

Eye health/surgeries: strabismus amblyopia glaucoma family history of eye issues _____

Do you or did you have sensitivity to: light noise busy environments

Diagnostic tests: MRI Computerized Posturography Hearing IMPACT/Cognitive testing

Previous surgeries/injuries:_____

Medications (prescription. Please include name, dose, and frequency):

_____

Over-the-counter medications (advil, motrin, alleve, Tylenol)

Allergies to medications, foods, or contrast agents (include reaction):

_____

Currently have difficulties with:_____

Goals for therapy:_____

Rate the following on a scale of 0 to 10 (0 if no symptoms, 10 is enough to severely interfere with function):

Headache: at rest_____ with activity_____

Dizziness: at rest_____ with activity_____

Cervical Pain: at rest_____ with activity_____

Disequilibrium: at rest_____ with activity_____