WWS Physical Therapy & Vestibular Rehabilitation

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Youth Concussion Medical History Form

Patient Name_____ Date of Birth_____

Reporter: ___Patient ___Parent ___Spouse ___Other:_____

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.

What is the date of your most recent concussion? _____

Which sport/activity were you participating in? _____

If sport related, what position were you playing at the time? _____

Did you continue to play after the injury? Yes No If yes, how long did you play for?

Were you wearing a helmet when you fell? Yes No

Have you continued to exercise since your injury? Yes No

Did your injury occur during: Practice Game Other:_____

Did you lose consciousness (get knocked out) at the time of your concussion? Yes No

If **yes**, for how long, approximately, were you unconscious? *(circle one)*
<1 minute 1-5 minutes 5-10 minutes >10 minutes

Do you have any accommodations at school? Yes No If yes, please specify _____

What is your current participation in school? Full day Half day Other:_____

Do you have an Individualized Education Program (IEP) at school? Yes No

Did you have any neck pain following your injury? Yes No

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

During which sport/activity did you sustain your concussion(s)? _____

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

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

___Attention deficit hyperactivity disorder (ADHD)
___Seizures
___Frequent headaches
___Dyslexia
___Motion sickness (ex. Car or plane rides)
___A learning disability
___Hypertension
___Depression
___Anxiety
___Diabetes
___Dizziness
___Noise in ears
___Double vision
___Migraines/family history of migraine

Have you have trouble with sleeping well?_____Headache_____Dizziness_____

Restless_____ Difficulty falling asleep_____Sleeping too much_____

Eye health/surgeries: strabismus amblyopia 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

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):

_____

Sports/Athletic activities: _____

Hours per week:_____

Level of Participation: Professional Collegiate High School Recreational Other:_____

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_____