1.0 YOUR PREVIOUS CONCUSSION HISTORY

Name___________________________ Grade: _____ Date of Birth ____/ ____/ ____

(Please complete this portion of the form with the assistance of your parent / guardian).

Note: A concussion is defined as: An injury most likely resulting from a blow to the head that causes a change in your mental status and can result in you experiencing, headache, nausea, vomiting, dizziness/balance problems, fatigue, difficulty sleeping, drowsiness, blurred vision, memory difficulty, or difficulty concentrating.

1.1 Have you had <u>any</u> Concussions in the last year (previous 12 months) in a Sport (school or club) or caused by any Activity (Ex: Motor Vehicle Accident, Work injury, Fall etc.) ☐ Yes ☐ No

If yes, please fill out the form below for each concussion you had within the last 12 months.

Concussion #1. When did the concussion occur: Month ______ Year ______

Did you lose consciousness (black-out) ☐ Yes ☐ No

Did you see an athletic trainer for help? ☐ Yes ☐ No

Did you see a physician or go to an emergency room for help? ☐ Yes ☐ No

How many days were you out of your sport or activities? _________ Days

Concussion #2. When did the concussion occur: Month ______ Year ______

Did you lose consciousness (black-out) ☐ Yes ☐ No

Did you see an athletic trainer for help? ☐ Yes ☐ No

Did you see a physician or go to an emergency room for help? ☐ Yes ☐ No

How many days were you out of your sport or activities? _________ Days

1.2 Have you had <u>any</u> Concussions before last year (longer than 12 months ago) in a Sport (school or club) or caused by any Activity (Ex: Motor Vehicle Accident, Work injury, Fall etc.) ☐ Yes ☐ No

If yes, please fill out the form below for each concussion you had prior to the last 12 months.

Concussion #3. When did the concussion occur: Month ______ Year ______

Did you lose consciousness (black-out) ☐ Yes ☐ No

Did you see an athletic trainer for help? ☐ Yes ☐ No

Did you see a physician or go to an emergency room for help? ☐ Yes ☐ No

How many days were you out of your sport or activities? _________ Days

Concussion #4. When did the concussion occur: Month ______ Year ______

Did you lose consciousness (black-out) ☐ Yes ☐ No

Did you see an athletic trainer for help? ☐ Yes ☐ No

Did you see a physician or go to an emergency room for help? ☐ Yes ☐ No

How many days were you out of your sport or activities? _________ Days

2.0 Concussion Symptom Scale

How do you feel? Score the following symptoms, based on how you feel right now even if you have never had a concussion or any other head injury. (Circle one response for each symptom)

Symptom	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

Do any of the symptoms get worse with physical activity? ☐ Yes ☐ No OR ☐ Not Applicable

Do any of the symptoms get worse with mental activity? ☐ Yes ☐ No OR ☐ Not Applicable

2.1 Symptom Score: ☐☐ (Max = 22) 2.2 Symptom Severity score: ☐☐☐ (Max = 132)

This completes the survey. Please give it to your school staff. THANK YOU