

Name: _____ **DOB:** _____ **MRN:** _____

Date: _____

Sport/Team/School: _____

Date/Time of Injury: _____

Years of Education Completed: _____

Age: _____

Gender: _____

Dominant Hand: Left / Neither / Right

How many diagnosed concussions has the athlete had in the past? _____

When was the most recent concussion? _____

How long was the recovery (time to being cleared to play) from the most recent concussion?

_____ (in days)

Has the athlete ever been:

Hospitalized for a head injury? Yes or No

Diagnosed/treated for headache disorder or migraines? Yes or No

Diagnosed with a learning disability/dyslexia? Yes or No

Diagnosed with ADD/ADHD? Yes or No

Diagnosed with depression, anxiety or other psychiatric disorder? Yes or No

Current medications? If yes, please list:

