Name:_____

Concussion Intake Information

When did your injury occur? Date: (_____) Time: (_____)
dd / mm / year 24:00

Past Medical History (BEFORE THIS INJURY):
prior concussions 1)_____ 2)_____ 3)_____
4)_____5)_____ 6)_____

Diabetes: Y / N ___ Epilepsy: Y / N ___ Meningitis: Y / N ___
Encephalitis: Y / N ___ Thyroid: hypo / hyper _____ Migraine history: self Y / N ___
Parents/siblings Y / N ___

Learning Disability: Y / N ___
Attention Deficit Disorder: Y / N ___ Anxiety: Y / N ___
Hyperactivity Disorder: Y / N ___ Depression: Y / N ___

Sleep Disorders: _____

Have you received therapy for your injury? Yes / No ___
If YES, where? _____
When? _____

What are your goals for rehabilitation? 1)_____
2)_____
3)_____

Hearing:

Do you have a hearing problem? Y / N ___
If yes, do you wear hearing aids? Y / N / L / R ___
Do you have noise sensitivity? Y / N ___
Do you have tinnitus (ringing, roaring, whooshing, buzzing)? Y / N ___
Have you seen an audiologist/ ENT about your hearing issues? Y / N ___
When?:_____

Concentration/Memory/Orientation:

Do you have difficulty planning/organizing/managing your schedule &/or initiating tasks? Y / N ___
Do you have difficulty concentrating? Y / N ___

Name:_____

Do you have difficulty remembering things? Y / N ___

Check off: reading ___ conversations ___ instructions ___
past events ___ appointments ___

Are you easily distracted when reading or having conversation? Y / N ___

Vision:

Do you have difficulty:
Watching television? Y / N ___
Reading a book/newspaper? Y / N ___
Looking at computer screens/electronics? Y / N ___
Being in busied environments (eg. Grocery store/mall) Y / N ___

Living situation:

Do you live alone? Y / N ___
If NO, whom do you live with?_____
Do you work? Y / N ___
If YES, what do you do for a living? _____
Full-time or Part-time _____
Are you presently working? Y / N ___

Schooling:

Are you returning or looking to attend school? Y / N / undecided _____
If yes, which will you attend?
High school / College/ University _____
_____year / grade

Driving:

Do you drive? Y / N ___
If yes, are you presently driving? Y / N ___
Do you feel that driving is exhausting? Y / N ___
Do you have difficulty being in busy traffic areas now? Y / N ___