

## UPMC Concussion Program

### General Information

Name \_\_\_\_\_ DOB \_\_\_\_\_

Height \_\_\_\_\_ ft \_\_\_\_\_ in      Weight \_\_\_\_\_

School/ Organization \_\_\_\_\_

Handedness: R or L or Both      Gender: Male or Female

### Language

Native Country \_\_\_\_\_

Native Language \_\_\_\_\_

### Education

Years of Education Completed (excluding kindergarten; e.g., high school senior is 11 years)  
\_\_\_\_\_ years

#### Check any of the following that apply:

- Received speech therapy
- Attended special education classes
- Repeated one or more years of school
- Diagnosed attention deficit disorder or hyperactivity
- Diagnosed learning disability

#### While in school, what type of student are/were you? (circle one)

Below Average      Average      Above average

### Sports

Current Sport/Activity: \_\_\_\_\_

Position/ event/ class \_\_\_\_\_

Level of participation \_\_\_\_\_

(e.g.: youth, middle school, high school, semi-professional, collegiate etc)

Years of experience at this level: \_\_\_\_\_

(Approximate if needed; e.g., high school senior is 3 years)

Concussion  
History

Number of times diagnosed with a concussion: \_\_\_\_\_

Total number of concussions that have resulted in loss of consciousness

Total number of concussions that resulted in confusion.

Total number of concussions that resulted in difficulty with memory of events occurring immediately **AFTER** injury.

Total number of concussions that resulted in difficulty with memory of events occurring immediately **BEFORE** injury.

Total number of games that were missed as a result of concussions.

Please List your five most recent concussions: \_\_\_\_\_  
(use approximate dates if needed)

Indicate whether you have experienced the following:

- Yes No Treatment for headaches by physician  
Yes No Treatment for migraine headaches by physician  
Yes No Treatment for epilepsy/ seizures  
Yes No History of brain surgery  
Yes No History of meningitis  
Yes No Treatment for substance/ alcohol abuse  
Yes No Treatment for psychiatric condition (depression, anxiety etc.)

Have you ever been diagnosed with the following?

- Yes No ADD/ADHD  
Yes No Dyslexia  
Yes No Autism  
Yes No Have you participated in strenuous exercise in the last 3 hours?

Total hours of sleep last night: \_\_\_\_\_hours

Current medications: \_\_\_\_\_  
\_\_\_\_\_