UPMC Sports Medicine

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:_____

_____