Patient Concussion/Head Injury Questionnaire

Name: _____ Date of Birth: _____

Date of Injury: _____

Referring MD: _____ Primary MD:_____

Diagnosis:_____

Description of Injury:_____

_____

When did you start noticing symptoms? _____

_____

What specific activities are you having difficulty with since your head injury?

_____

_____

What specific goals/outcomes would you like to achieve from therapy? -

_____

_____

Have you sought previous treatment for your current condition? (check all that apply)

___ Physical/Occupational/Speech Therapy ___Chiropractor
___Injections ___Massage therapy ___Other: _____

What diagnostic tests have you had for this problem (X-ray, MRI, EMG, etc?): _____

_____

Previous Concussions: How many? _____ Dates: _____

Is this a worker's compensation injury? Yes No

- If yes, please fill out the back page of this packet

Have you been seen by a physician since your injury? Yes No

Please list any restrictions your doctor has given you (i.e. lifting, driving): _____

_____

When are you scheduled to see your doctor again? _____

ST. FRANCIS
Regional Medical Center

Medications: Please list all of your medications and the additional information requested if possible.

Medication	*Reason*	*Start Date*

Please rate your pain (0 = no pain, 10 = worst pain imaginable):
Today's pain: _____ Worst pain: _____ Least pain_____
Acceptable pain rating: _____

Patient's Medical History *Please answer each "Yes" or "No" question relating to your medical history Please explain any "Yes" answers in the comments section below*					
Question	Yes	No	*Question*	Yes	No
Any Surgeries			Allergies		
Serious Injuries			Excessive Vomiting		
Migraines			Depression		
ADD/ADHD			Anxiety		
Diabetes			Seizures		
Heart Problems			Meningitis		
Learning Disabilities			Dizziness		
Sinus Problems			Tonsil/Adenoid/ Chronic Ear Infections		
Headaches			Lung/ Bronchial Problems		
Hearing Problems			Vision Problems? Glasses?		
Chronic Colds/ Respiratory Infections			Motion Sickness		
Comments (please include date, results, and any follow up care for surgeries or chronic conditions):					

Personal History of mental health concerns (ie – depression, anxiety)? Yes No
If so, what _____

Have you recently experienced any significant changes in:

__ Mood
__ Interest or pleasure in daily activities
__ Unexpected loss/gain of weight
__ Sleeping habits
__ Concentration
__ Recurrent thoughts of death or harming yourself
__ Energy level (restlessness, lethargy, or fatigue)
__ Memory

Please complete this page if you are a student.

School Age Questionnaire

School: _____ Grade: _____

Current Extracurricular/Sports Activities: _____

_____

1. What is difficult at school? _____
   _____
   _____

2. Are you following any recommendations regarding school from your medical provider?
   _____
   _____
   _____

3. Are you aware of / implementing cognitive rest activity restrictions? Yes No
   If so, what have you been trying? _____
   _____
   _____

4. What is your current school schedule (order of classes/ time of day)?

	Class	Time (approx.)
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

Person Completed this form: □ **Self** □ **Parent/Caregiver** □ **Other:**_____

ST. FRANCIS
Regional Medical Center

Please complete this form if you are working or this is worker's comp injury

Work Questionnaire

Are you currently employed? Yes No

Are you currently on leave from work? Yes No

How many hours per week do you normally work? _____

Employer:_____ Occupation:_____

Description of Job Duties:_____

_____

_____

1. What is difficult at work? _____
   _____
   _____
   _____
2. Are you following any recommendations regarding work / work restrictions from your medical provider? _____
   _____
   _____
   _____
3. Are you aware of / implementing cognitive rest activity restrictions? Y / N
   If so what have you been trying? _____
   _____
   _____
   _____
   _____

Person Completed this form: □ **Self** □ **Parent/Caregiver** □ **Other:_____**

ST. FRANCIS
Regional Medical Center