Sports Concussion Symptom Questionnaire

Initial Assessment – Sports Medicine

Name: _____ MRN: _____

Current Sport/team: _____

Date/time of injury: _____ Date of evaluation: _____

Years of education completed: _____

Primary language: _____ Second language: _____

Other sports played: _____

Current Symptoms

Please rate how much the following symptoms bother you TODAY.							
	None	**Mild**		**Moderate**		**Severe**	
Headache	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
"Pressure in head"	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Neck pain	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Nausea or vomiting	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Dizziness	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Blurred vision	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Balance problems	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Sensitivity to light	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Sensitivity to noise	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Feeling slowed down	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Feeling like "in a fog"	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
"Don't feel right"	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Difficulty concentrating	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Difficulty remembering	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Fatigue or low energy	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Confusion	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Drowsiness	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Trouble falling asleep	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
More emotional	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Irritability	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Sadness	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Nervous or anxious	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

Sports Concussion Symptom Questionnaire

Initial Assessment

<u>Have you ever had a concussion BEFORE THIS ONE</u>? Yes / No If NO skip to next section.

Number of PREVIOUS Concussions: _____

Diagnosed by a physician: _____

resulting in loss of consciousness: _____

resulting in loss of memory for events *prior to* concussion: _____

resulting in loss of memory for events *after* concussion: _____

resulting in confusion: _____

resulting in seizures: _____

What was the longest your symptoms lasted after any previous concussion? (# of days, weeks, months or years) _____

If you have had multiple concussions in the past (more than this one), did less force cause a re-injury? **Yes / No**

<u>Do you have a history of headaches</u>? Yes / No If NO skip to next section.

What kind of treatment have you had for these headaches? _____

Do you have a history of migraine headaches? _____

Does anyone in your family have a history of migraine headaches? _____

<u>Please tell us if you have any of the following</u>:

Learning disability **Yes / No** If yes, what kind? _____

Attention-Deficit/Hyperactivity Disorder **Yes / No**

Have you repeated or skipped a grade? **Yes / No** If yes, which one(s): _____

What type of student are you? Above Average / Average / Below Average

Anxiety **Yes / No** Depression **Yes / No**

Sleep Disorder **Yes / No** Other Psychiatric Disorder **Yes / No**

Drug or Alcohol Abuse **Yes / No**

What current stressors do you have in your life? _____

<u>Do you have any medical problems (such as hypothyroid, seizures, etc.)?</u>