CONCUSSION NEW PATIENT FORM

Patient Name_____ **DOB:**_____ **Age:**_____

Parent's Name_____ **Home #:**_____ **Cell #:**_____

Preference Home?___ **or cell?**___ **E-mail address:**_____

School:_____ **Grade:**_____

Pediatrician/Referring Physicial_____ **Phone #:**_____

CURRENT INJURY

Date of Injury_____ **Sport**_____ **Helmet/headgear on?**_____

Description of Injury_____

Was there loss of consciousness? Yes NO Duration?_____
Was there amnesia (loss of memories) before the injury? Yes No
Did anyone notice sieizure activity? YES NO
Were any of the following signs identified?

___sluggishness	**___appearing dazed**	**___forgetful**
___repeating questions	**___answers questions slowly**	**___confused**

Have you been evaluated for this injury? YES NO
Location of evaluation: PCP ER NEUROLOGIST
Were you hospitalized overnight? YES NO
Have any imaging studies been done: X-rays YES NO results_____
CT YES NO results_____
MRI YES NO results_____

What have you done since the injury?_____

Are you taking medications: YES NO If yes, what medication_____
Are you attending school? YES NO Gym class? YES NO
Have you attended sporting activities? YES NO
Have you had a prior history of concussion? YES NO (if no, skip next 5 questions)
How many? 1 2 3 4 5 When was your last concussion?_____

Please list the dates and amount of time missed in school/sports for each one._____

What was your longest duration of symptoms after a concussion?_____

Do you feel like less severe trauma is inducing headache symptoms? Yes No
Do you or any family members have a history of headache treatment or migranes?
Patient Yes No Family member Yes No
Do you have a history of learning disability, ADHD, or developmental disorders?
Yes No If yes, treatment?_____

RISK FACTORS FOR PROLONGED RECOVERY
Do you have a history of anxiety, depressions, or sleep disorders? Yes No

How would you rate how you feel today compared to your normal self:

Normal 0 1 2 3 4 5 6 Very different

How would your parent rate you?

Normal 0 1 2 3 4 5 6 Very different

PAST MEDICAL HISTORY
Do you have any medical problems for which you were treated for regularly either now or in past? Please describe_____
_____
_____

Hospitalizations (overnight) Yes No
If yes, explain_____
_____

Medications_____**Allergies**_____

Surgeries_____

SOCIAL HISTORY
Who lives at home with you?_____

What do you like to do when you are not in school?_____
_____

What sports are you involved with?_____
_____

Patient Name: _____

Insurance: _____

Policy Number: _____

Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect that your insurance may not pay for the item or service listed below.
If your insurance doesn't pay for the services listed below, you will be responsible.

Item or Service	Reason why it may not be covered	Estimated Cost
NEURO TEST BY COMPUTER (ImPact) 96120	Your insurance plan doesn't cover it	$ 50

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below.

Options: Check only one option. We cannot choose a box for you.

- **Option 1.** I want the item/service listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment. I understand if my insurance doesn't pay, I am responsible for payment, but **I can appeal their decision** by following my plan provisions. If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

- **Option 2.** I want the item/service listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed.**

- **Option 3.** I don't want the item/service listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

Additional Information:

This notice gives our opinion, not an official insurance decision. Please contact your insurance company with further questions. By signing below, you are acknowledging that you received and understand this notice.

Signature:	Date:

Post-Concussion Symptom Inventory

Name:_____ Age/Grade:_____ Injury Date:_____

Please Circle the number to tell us how much of a problem the following symptoms are for you **CURRENTLY**

Please rate the symptoms on the following scale: **0 = Not a problem 3 = Moderate 6 = Severe**

	Date:	Date:	Date:	Date:	Date:	Date:
Headache	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Nausea	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Vomiting	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Balance problems	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Fatigue	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Trouble falling asleep	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Sleeping more than usual	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Sleeping less than usual	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Sensativity to light	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Senstativity to noise	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Irritability	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Sadness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Nervousness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Feeling more emotional	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Numbness or tingling	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Feeling slowed down	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Feeling mentally "foggy"	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Difficulty concentrating	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Difficulty remembering	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Visual Problems (double vision, blurring)	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Feeling dazed or stunned	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Get confused with directions or tasks	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Move in a clumsy manner	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Answer questions more slowly than usual	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
In general, to what degree do you feel differently than before the injury (not feeling like yourself)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4