BrainCARE

Concussion ◆ Assessment ◆ Recovery ◆ Education

CONCUSSION PATIENT – INITIAL VISIT

NAME: _____DATE OF BIRTH:_____ CURRENT DATE:_____

*****PLEASE COMPLETE THE 22 QUESTION BRAIN HEALTH SYMPTOM INVENTORY*****

DATE/TIME OF HEAD INJURY:

PLEASE DESCRIBE IN DETAIL HOW THE HEAD INJURY OCCURRED.

(CIRCLE YES / NO) DID YOU LOSE CONSCIOUSNESS, IF SO, FOR HOW LONG?

WHAT WERE YOUR INITIAL SYMPTOMS:

(CIRCLE YES / NO) WERE YOU SEEN AT URGENT CARE, EMERGENCY ROOM, OR HOSPITAL? IF YES, WHERE? WHAT WAS DONE THERE? WERE YOU HOSPITALIZED OVERNIGHT/HOW LONG?

WHAT SYMPTOMS/PROBLEMS HAVE YOU BEEN HAVING SINCE THE INITIAL INJURY?

WHAT IS YOUR MAIN COMPLAINT(S) TODAY?

COMPARED TO BEFORE THE INJURY, HOW ARE YOU DOING TODAY: _____% OUT OF 100%

HOW MUCH BETTER SINCE THE INITIAL INJURY: _____%

(CIRCLE YES / NO) HAVE YOU EVER SUFFERED ANY OTHER HEAD INJURIES PRIOR TO THE CURRENT INJURY? IF YES, WHEN DID THIS HAPPEN? WAS IT SPORTS RELATED? WHAT TYPE OF TREATMENT, IF ANY, WAS DONE?

braincareclinic@gmail.com

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(CIRCLE YES / NO) DO YOU NOW OR HAVE YOU EVER PLAYED A CONTACT SPORT SUCH AS IN HIGH SCHOOL, COLLEGE, ETC? IF SO, WHAT TYPE OF SPORT? WHAT POSITION DID YOU PLAY? WERE YOU EVER TREATED FOR A CONCUSSION?

(CIRCLE YES / NO) ARE YOU A MILITARY VETERAN: WHICH BRANCH; ENTRY DATE; SIGNIFICANT TRAINING (AIRBORNE, BUDS/SEAL, SF-Q) DEPLOYMENTS TO ACTIVE WARZONES IN WHAT CAPACITY; ANY INJURIES NOT COVERED ABOVE; ETS/LOS RETIREMENT/MEDICALLY RETIRED? % DISABILITY RATING (DOD OR VA)?

WHAT IS YOUR CURRENT VOCATION/PROFESSION/GRADE IN SCHOOL?

HAS THIS HEAD INJURY AFFECTED YOUR ABILITY TO FUNCTION AT WORK/SCHOOL?

WHAT ARE YOUR CURRENT STRESS LEVELS AT HOME/WORK/SCHOOL?

PLEASE LIST ALL PAST MEDICAL HISTORY. □ NONE

SURGICAL HISTORY (LIST OPERATIONS) □ NONE

PLEASE LIST MEDICATIONS CURRENTLY TAKING: □ NONE

PLEASE LIST SUPPLEMENTS CURRENTLY TAKING: □ NONE

PLEASE LIST ANY THERAPY, TREATMENTS, MEDICATIONS, SUPPLEMENTS YOU HAVE TRIED AND STOPPED. PLEASE EXPLAIN THE REASON FOR STOPPING.

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(CIRCLE YES / NO) TOBACCO USE (IF SO, HOW MUCH?)

(CIRCLE YES / NO) ALCOHOL USE (IF SO, HOW MUCH?)

(CIRCLE YES / NO) CANNABIS USE (IF SO, HOW MUCH?)

HOW WOULD YOU DESCRIBE YOUR DIET/DAILY EATING HABITS?:

HOW WOULD YOU DESCRIBE YOUR DAILY EXERCISE HABITS (HOW MUCH/HOW OFTEN/WHAT INTENSITY):

WHAT DO YOU LIKE TO DO TO KEEP YOUR BRAIN COGNITIVELY ACTIVE?

ANY OTHER INFORMATION YOU BELIEVE I SHOULD KNOW THAT WILL HELP ME BE A BETTER PARTNER WITH YOU IN YOUR HEALTHCARE AND RECOVERY.

MOST IMPORTANTLY, WHAT ARE YOUR GOALS? WHAT DOES SUCCESS LOOK LIKE FOR YOU? WHAT DO YOU HOPE TO GET OUT OF OUR DOCTOR-PATIENT RELATIONSHIP?