HEAD STRONG DIAGNOSTICS, LLC

Concussion Questionnaire

The following questions are asked so that we can better understand you. This type of information is very helpful in making an accurate diagnosis and providing recommendations. Please read the questions carefully and answer as fully as possible. We will have the opportunity to discuss these questions in detail at the time of your appointment. Thank you.

PLEASE PRINT

TODAY'S DATE_____ DATE OF CONCUSSION _____

NAME _____

BIRTHDATE_____ AGE_____ SSN _____

ADDRESS _____

_____

HOME PHONE_____ OTHER PHONE_____

REFERRED BY:_____ PHONE:_____

Please describe, in detail, what you can remember about the events surrounding your head injury:

_____

_____

_____

_____

_____

_____

What symptoms have you experienced as a result of this injury? _____

_____

_____

Have you ever had a concussion previously? YES_____ NO_____ If yes, how many, when and please describe each_____

_____

_____

What treatment, if any, have you received? _____

_____

What is your primary language?_____Do you speak any other languages? _____

Are you color-blind? YES_____NO_____

MEDICAL HISTORY

Have you ever undergone any type of surgery? YES__ NO___ If yes, what type of operation did you have, how old were you, how long were you hospitalized, or was the surgery performed on an outpatient basis?

_____

_____

Have you suffered any other type of head injury? YES___NO___If yes, please indicate your age, how you were injured and whether or not consciousness was lost at the time of the incident, and if so, for how long:

_____

_____

_____

Have you ever experienced seizures or convulsions? YES_____NO_____If yes, please explain:

_____

_____

_____

Please place an "X" to indicate if you have had any of the following medical problems:

☒☒	**Medical Condition**
	Attention Deficit/Hyperactivity Disorder (ADD or ADHD)
	Allergies
	Asthma
	Depression
	Diabetes
	Drug Use/Abuse
	Emotional Problems (depression/anxiety)
	Encephalitis
	Epilepsy
	Learning Disability
	Lead poisoning/exposure
	Migraines
	Multiple sclerosis
	Seizures
	Other (please specify)

PRESENT MEDICAL STATUS

Current Health:_____(Please rate poor, fair, good, excellent, etc.)

Present height:_____ weight: _____

Are you in any way physically ill at this time? YES NO If yes, please explain and specify if you are currently being treated for this illness: _____

_____

_____

Please list any medication you are currently taking:

Medication Dose (e.g. 20mg four times a day) Date Started

_____

_____

_____

_____

Do you currently or have you ever smoked cigarettes? YES_ NO If yes, how much do you smoke per day and what brand of cigarettes? _____

_____

On average, how much alcohol do you typically drink in one week? _____

Have you ever, or do you currently use any illegal drugs such as pot, coke, etc.? (**This information is used strictly to inform us of your medical condition and will not be shared with <u>anyone</u> without your permission, including the police.)** _____

_____

_____

Please place an "x" in the column if you have experienced any of the following the symptoms since the concussion (regardless if it is related to the concussion or not). For each one you check, rate how much you are experiencing the symptom TODAY, by rating it on a scale from 1 to 5 (1 = very little, 5 = very much)

☒☒	**SYMPTOM**	**RATE SYMPTOM 1 - 5**
	Loss of Consciousness w/injury	NA
	No memory for injury	
	Headaches	
	Difficulty concentrating	
	Difficulty paying attention	
	Difficulty remembering things	
	Missed appointments	
	Feeling irritable	
	Difficulty sleeping (too much or not enough)	
	Difficulty falling asleep	
	Dizziness	
	Nausea	
	Vomiting	
	Problems with balance	
	Feelings of sadness	
	Numbness or tingling	
	Fatigue	
	Feeling mentally "slow"	
	Sensitive to light	
	Sensitive to noise	
	Double vision/blurry vision/ seeing spots	

Are you currently, or have you ever been involved in any type of professional mental health treatment (i.e., psychotherapy, family counseling, etc.)? YES _____ NO_____ If yes, please list:_____

_____

_____

EDUCATIONAL HISTORY:

Years of education:_____Highest degree earned: _____

Name of School: _____

Did you repeat any grades? YES_____NO_____If yes, which ones and for what reason(s)? _____

_____

_____

Did you fail any subjects? YES___NO___If yes, which ones? _____

_____

Did you receive special education services? YES_____NO_____. If yes, specify type (i.e., self-contained class, resource room, reading or math lab, etc.):

_____

_____

Please indicate if you have ever had any of the following problems in school.

☒☒	**Condition**
	Attention problems
	Discipline problems
	Failing grades
	Failing subjects
	Math difficulties
	Reading difficulties
	Social situations
	Writing difficulties

****

Please use this space for any additional information/comments you wish to share with us about yourself: