**PEDIATRIC CONCUSSION INTAKE FORM**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_

Language(s) other than English spoken in home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sport(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position in Sport(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mechanism of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tested positive at any point for COVID-19? Yes No; If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of Consciousness? Yes No Do you recall impact? Yes no

Were you/your child removed from play due to injury? Yes No

*Answer the following Questions please (circle one):*

Have you ever been diagnosed with ADD/ADHD? Yes No

Have you ever been diagnosed with Dyslexia? Yes No

Have you ever been diagnosed with Autism? Yes No

Have you ever been diagnosed with a learning disability/issue(s)? Yes No

*If yes, what type?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received Speech Therapy? Yes No

Have you had an IEP/504 plan in school? Yes No

Have you repeated one or more years of school? Yes No

When in school, what type of student were/are? Below Average Average Above Average

Please list ALL concussion dates and length of recovery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Indicate whether you had any of the following (Circle one):*

Chronic Headaches (non-concussion related)? Yes No

Chronic Migraines Yes No

Epilepsy/Seizures Yes No

Brain Surgery Yes No

Sleep Disorder (ex: Insomnia) Yes No

*If yes, What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Meningitis Yes No

Substance Abuse/ETOH Abuse Yes No

Mental Health Condition (anxiety, depression etc.) Yes No

*If yes, which type(s)?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please circle the early signs that were reported after the injury:*

Headache Appeared dazed/confused Sensitivity to light Sensitivity to noise

Balance issues Is confused at events Dizziness Fogginess

Irritability Answered questions slowly Visual Changes Forgetful

Neck pain Repeated questions Nausea Vomiting

*Where was the location of your impact?*

No head impact Front of head Back of head Left side of head

Right side of head Unsure

*Who have you been evaluated by?*

Pediatrician Athletic Trainer Emergency Center Urgent Care Other Physician/NP/PA

*Who recognized that you had a concussion?*

Athletic trainer Coach Self Parent School Nurse Teacher Teammate Other:\_\_\_\_\_\_\_

*Have you returned to school?*

Full day Half Day Not in school

Have you returned to any Physical activity/Exercise after the injury? Yes No

Have you had any imaging (ex: MRI, CT scan)? Yes No

If yes, what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the first day of your last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many periods have you had in the last 12 months? \_\_\_\_\_\_\_\_\_\_\_\_\_ N/A: \_\_\_\_\_\_\_\_\_\_\_\_\_

What age were you at your first period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A: \_\_\_\_\_\_\_\_\_\_\_\_\_

**PHQ-9 Depression Screening**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the **last 2 weeks**, how often have you been bothered by any of the following problems? | Not at all | Several Days | More than half of the days | Nearly Every day |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed or being so fidgety/restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Symptoms Today** | 0 (None) | 1 (Mild) | 2 | 3 Mode | 4 rate | 5 | 6 (Severe) |
| Headaches | 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 | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 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 Sound | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Feeling like “in a fog”  | 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/Low Energy/Slowed Down | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Confusion | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Drowsiness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| More Emotional | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| More Irritable | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sadness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Nervous/Anxious | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sleep Disturbance | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Abnormal Heart Rate | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Excessive Sweating | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Do symptoms worsen with physical activity? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Do symptoms worsen with cognitive (thinking) activity? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| How normal (your baseline) do you feel? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

*Have you had any other symptoms/injuries in association with you head injury not reported above?*

Loss of appetite w/o Nausea Indigestion Weight Loss Ringing in the ear

Neck Pain Back Pain Speech Issues Feeling Clumsy Skull Fracture

Brain Bleed Seizure Pain in arm, legs or joints Chest pain Ear Pain

Stomach or Bowel Problems Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GAD-7 Anxiety Screening**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the **last 2 weeks**, how often have you been bothered by any of the following problems? | Not at all | Several Days | More than half of the days | Nearly Every day |
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Worrying too much about different things | 0 | 1 | 2 | 3 |
| Trouble relaxing | 0 | 1 | 2 | 3 |
| Being so restless that it’s hard to sit still | 0 | 1 | 2 | 3 |
| Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

**MIDAS**

Please answer the following questions about ALL of the headaches you have had over the **last 3 months.** Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months.

\_\_\_\_\_1. On how many days in the last 3 months did you miss work or school because of your headaches?

\_\_\_\_\_2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

\_\_\_\_\_3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

\_\_\_\_\_4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

\_\_\_\_\_5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

Total Score: 0-5 6-10 11-20 21+