VANDERBILT UNIVERSITY
MEDICAL CENTER

Vanderbilt Sports Concussion Center

New Patient Assessment Form

Date of Injury: _____ Sport: _____

Game: _____ Practice: _____

How did it happen? _____

Did you lose consciousness? Yes No How long were you unconscious? _____

At the time of injury did you have any of the following symptoms:

_____ headache	_____ numbness or tingling	_____ confusion
_____ vomiting	_____ sensitivity to noise	_____ weakness
_____ nausea	_____ sensitivity to light	_____ personality changes

How long did these symptoms last? _____

Did you lose memory of events before _____ or after _____ the injury?

Did you miss any games/practices/days of school? Yes No If so, how many? _____

Were you evaluated onsite by an athletic trainer or doctor? Yes No

Were you evaluated in an emergency room? Yes No

Did you get an MRI or CT scan? Yes No If yes, where _____

Please list any other concussions or head injuries you have had:

Date _____ Were you knocked out? _____ Did you have memory loss? _____

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What were your major symptoms with earlier concussions and how long did they last?

Symptom _____ How long? _____

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Symptom _____ How long? _____

Have you ever been diagnosed with or treated for:

_____ headaches	_____ ADHD	_____ learning disability	_____ migraine headaches
_____ meningitis	_____ brain surgery	_____ alcohol/drug abuse	_____ seizures
_____ dyslexia	_____ autism	_____ anxiety/depression	

Have you ever:

had speech therapy? _____ taken special education classes? _____ repeated a grade? _____

Has anyone in your family had:

Alzheimer's disease? _____ dementia? _____ migraine headaches? _____