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
- ______ vomiting
- ______ nausea
- ______ numbness or tingling
- ______ sensitivity to noise
- ______ sensitivity to light
- ______ confusion
- ______ weakness
- ______ 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?  ______