Somerset Pediatric Group
Concussion Intake Form for Existing SPG Patients

Child's Name: _________________ Age: ________ Child DOB: __________________

Today's Date _____

Date you sustained the concussion _____________

Please describe how you injury occurred and the location on the head or body (if force transmitted to the head)

Please circle the symptoms that you had within 12 hours of the injury:

Headache	Vision Changes	Dizziness	Balance Problems
Nausea	Vomiting	Ringing in the Ears	Personality Changes
Disoriented	Felt like you had your bell rung or been dinged		Confused about events

Loss of Consciousness (How long? ____________)
Do not remember events just BEFORE the injury (How long? ____________)
Do not remember events just AFTER the injury (How long? ______________)
Have you seen any other physicians/clinicians for this problem? (if yes, please explain)

Have you had any imaging following your concussion? (If yes, list studies obtained and where they were done)

Prior Concussions:

How many concussions have you had in the past? 0 1 2 3 4 5 6+

If you have sustained a concussion in the past please provide the date of injury, how the injury occurred, initial symptoms (was there loss of consciousness, amnesia, or confusion/disorientation), duration of symptoms, and how long it took for you to return to sports after the injury.

Patient Medical History:

	Yes	**No**	**Comments**
History of ADHD/ADD:			________________
History of Dyslexia or Learning disabilities:			________________
History of special education/504/IEP:			________________
History speech/reading therapy:			________________
History of vision therapy:			________________
History of eye surgery, strabismus, lazy eye:			________________
History of mood disorders including depression, anxiety:			________________
History of migraine headache/frequent headaches:			________________
History of car (motion) sickness:			________________
Do you like to read:			________________
Are you a slow reader:			________________
History of snoring/sleep problems			________________
Corrective Lenses:			________________
Far / Near sightedness/Astigmatism			________________

Family History:

Siblings, Parents or Grandparents with any of the following:

	Yes	No	Relative
Mental illness (depression, anxiety, etc)			____________________
Neurologic disorders/Migraines			____________________

Current Health (ROS):

Have you noticed any of the following symptoms in your child or does your child complain of:

	Yes	No	Comments
Constitutional: Unexplained weight loss/gain, fever, chills, sweats			________
Eyes: Glasses/contacts, blurred/double vision			________
ENT: Ringing in ears/hearing problems			________
CV: chest pain/ heart palpitations			________
Respiratory: shortness of breath/cough/wheezing			________
GI: heartburn/constipation			________

Social History:

School ____________________________ Grade _______________________

Performance in school (circle one): Above Average Average Below Average

What Sports/Activities does the patient participate in? □ None (or specify below) __________________

____

Language spoken at home ______________________________________

Which best describes the patient's living arrangements? (check all that apply)

Lives with both biological parents

Lives with one parent/guardian (circle one) (mother, father, grandparent, other)

Specify who is the legal guardian (mother, father) other ______________

Does the patient smoke? YES NO (circle one)