Somerset Pediatric Group
New Patient Concussion Intake Form

Child's Name: _____ Age: _____ Child DOB: _____

Today's Date _____

Date you sustained the concussion _____

Please describe how your 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 or 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			_____

Does your child have any on medical conditions: _____

Allergy History:

Drug allergies: □ None Known □ Yes (Please list your child's allergies and the reaction)

_____

Food Allergies: □ Yes □ No (If yes, what is the reaction) _____

Medications (prescription, over the counter, and vitamins):

_____

_____

Past Surgeries: : □ Yes □ No (If yes, list all surgeries and what year surgery was performed):

_____

_____

Prior Hospitalizations: □ Yes □ No (If yes, what was the reason for the hospitalization and what year):

_____

Family History:

Siblings, Parents or Grandparents with any of the following:

	Yes	No	Relative
Heart Disease			_____
Heart attack before age 50			_____
Mental illness (depression, anxiety, etc.)			_____
Neurologic disorders/Migraines			_____
Unexplained sudden death			_____
Cancer			_____

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)