

# Office-Based Concussion Evaluation

(For use in clinic setting)

Name: \_\_\_\_\_ Referral Source: \_\_\_\_\_ N/A  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Level of Education: \_\_\_\_\_ School: \_\_\_\_\_  
 Date of Evaluation (Today's Date): \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Time Since Injury: \_\_\_\_\_  
 Person Reporting: \_\_\_ Patient \_\_\_ Parent \_\_\_ Spouse \_\_\_ ATC \_\_\_\_\_ Other \_\_\_\_\_

**Cause:** \_\_\_ MVA \_\_\_ Ped-MVA \_\_\_ Fall \_\_\_ Assault \_\_\_ Sport (specify) \_\_\_\_\_  
 \_\_\_ Practice \_\_\_ Game Position: \_\_\_\_\_ Mouthguard: Y / N Type: bite & boil custom  
**Mechanism of Injury:** \_\_\_ Head to Head \_\_\_ Head to Ground \_\_\_ Head to Body Part \_\_\_\_\_ Other \_\_\_\_\_  
**Location of Contact:** \_\_\_ Frontal \_\_\_ R / L Temporal \_\_\_ R / L Parietal \_\_\_ Occipital \_\_\_ Neck Other \_\_\_\_\_  
**Injury Description:** \_\_\_\_\_  
 \_\_\_\_\_  
**Loss of Consciousness:** Y / N Duration: \_\_\_\_\_  
**Amnesia (Retrograde):** Loss of memory of events **before** the injury? Y / N Duration: \_\_\_\_\_  
**Amnesia (Anterograde):** Loss of memory of events **after** the injury? Y / N Duration: \_\_\_\_\_  
**Early Signs:** \_\_\_ Dazed or stunned \_\_\_ Confused or disoriented \_\_\_ Answered questions slowly \_\_\_ Repeated questions \_\_\_ Forgetful  
**Seizures:** Were seizures observed? Y / N **Same Day Return-to-Play** Y / N Describe: \_\_\_\_\_  
 Overall, how severe would you rate your problems with this injury? 0 1 2 3 4 5 6  
**Previous Provider:** \_\_\_\_\_ Date: \_\_\_\_\_ CT or MR Imaging \_\_\_ Yes \_\_\_ No Results: \_\_\_\_\_

Symptom Check List: Initial (day of injury) and Current (at the time of evaluation) – Rate severity on scale from 0-6

Physical (10)	Initial	Current	Cognitive(4)	Initial	Current	Sleep (4)	Initial	Current	NA
Headache			Feeling mentally foggy			Drowsiness			
Nausea			Feeling slowed down			Sleeping less than usual			
Vomiting			Difficulty concentrating			Sleeping more than usual			
Balance problems			Difficulty remembering			Trouble falling asleep			
Dizziness			<b>COG Total Score</b>			<b>SLEEP Total Score</b>			
Visual problems			<b>COG Total Symptoms</b>			<b>SLEEP Total Symptoms</b>			
Fatigue			<b>Emotional (4)</b>	<b>Initial</b>	<b>Current</b>	<b>Headache</b>			
Sensitivity to light			Irritability			Type: Throbbing/Pressure/Dull			
Sensitivity to noise			Sadness			Location: R or L Top/Frontal/Parietal/ Occipital/Generalized			
Numbness/Tingling			More emotional			Neck Pain? Y / N			
			Nervousness			Worse in AM / PM			
<b>PHYS Total Score</b>			<b>EMO Total Score</b>			Headache worse with cognitive exertion? Y / N			
<b>PHYS Total Symptoms</b>			<b>EMO Total Symptoms</b>			Describe:			
<b>TOTAL SCORE</b>			<b>TOTAL SYMPTOMS</b>			Headache worse with physical exertion? Y / N			
Do these symptoms get worse with physical activity? Y / N / NA						Describe:			
Do these symptoms get worse with cognitive activity? Y / N / NA									

Risk Factors for Protracted Recovery (Check all that Apply)

Concussion history Y / N	
Previous #	1 2 3 4 5 6+
Longest symptom duration	Days _____ Weeks _____ Months _____ Years _____
If multiple concussions, did less force cause reinjury? Y / N	

Development history	
Learning disabilities	
Attention-Deficit/ Hyperactivity Disorder	
Other developmental disorder:	

Psychiatric history	
Anxiety/Depression	
Sleep Disorder	
Other psychiatric disorder:	

Headache history	
Prior tx for HA	
History of migranes	
Family history of migraines or headache	

Medications: \_\_\_\_\_

Other medical history: \_\_\_\_\_

Immediate Memory (Circle 'C' if correct, 'I' if incorrect)									
I am going to read to you a list of words and, when I am done, repeat as many words as you can remember in any order. (Repeat process for trial 2 and 3).									
List	Trial 1		Trial 2		Trial 3		Alternative Word Lists		
Elbow	C	I	C	I	C	I	Candle	Baby	Finger
Apple	C	I	C	I	C	I	Paper	Monkey	Penny
Carpet	C	I	C	I	C	I	Sugar	Perfume	Blanket
Saddle	C	I	C	I	C	I	Sandwich	Sunset	Lemon
Bubble	C	I	C	I	C	I	Wagon	Iron	Insect

Concentration (Circle 'C' if correct, 'I' if incorrect)				
I am going to read to you a string of numbers and, when I am done, you repeat them back to me backwards, in reverse order of how I read them to you. For example, if I say 719 you would say 917.				
List	Trial		Alternative Number Lists	
4-9-3	C	I	6-2-9	5-2-6
3-8-1-4	C	I	3-2-7-9	1-7-9-5
6-2-9-7-1	C	I	1-5-2-8-6	3-8-5-2-7
7-1-8-4-6-2	C	I	5-3-9-1-4-8	8-3-1-9-6-4
				7-2-4-8-5-6

	Normal	Abnormal
General appearance		
Describe:		

Pupil / Eye Exam			
Pupil appearance	Eyes	Normal	Abnormal
Dilated	Reaction		
Constricted	Horizontal motion		
Nystagmus	Unequal		

Motor and Balance	Normal	Abnormal
Fine movement of hands		
Finger-to-nose task		
Gait		
Tandem walk		
Rhomberg test		
Advanced balance testing*		
*Have athlete stand heel-to-toe with eyes closed, and hands on hips, for 20 seconds while trying to maintain stability (Non-dominant foot in back)		

Delayed Recall (Circle 'C' if correct, 'I' if incorrect)				
Do you remember that list of five words I read earlier? Tell me as many words from the list as you can remember, in any order				
List	Trial		Alternative Word Lists	
Elbow	C	I	Candle	Baby
Apple	C	I	Paper	Monkey
Carpet	C	I	Sugar	Perfume
Saddle	C	I	Sandwich	Sunset
Bubble	C	I	Wagon	Iron

Follow-up Plan

- No follow-up needed, unless signs or symptoms return
- Follow-up in clinic: Time until next follow-up \_\_\_\_\_
- Referral to Sports Concussion Clinic
- Other Referral
  - Neuropsychology
  - Neurology
  - Physical Therapy
  - Other: \_\_\_\_\_
  - Neurosurgery
  - Physiatry
  - Speech Therapy
- CT / MRI
- Emergency Department

Report Completed by \_\_\_\_\_