NORTHSIDE HOSPITAL
CONCUSSION INSTITUTE

PATIENT HISTORY FORM (Pediatric: 5-18 years)
Concussion Institute

HOW TO PREPARE

Please complete the Patient History form prior to your arrival. If you are unable to complete the form prior to your appointment, please arrive 30 minutes before your appointment time. Wear or bring comfortable clothes and shoes that you can exercise in, especially athletes.

Please bring any of the following medical records, if available:

- ImPACT Passport ID or a copy of ImPACT test records
- Psychological, psychoeducational, or neuropsychological testing reports and/or records
- Medical records related to your current concussion (CT notes, ED discharge summary, etc.)
- Medical records related to previous concussions or traumatic brain injuries
- School accommodation plans, such as an IEP or 504 Plan

WHAT TO EXPECT

How long will my appointment last?
Initial appointments can last 1 ½ to 2 hours. We may require more time depending on your medical history.

Who will I see?
You will meet with a Neuropsychologist and an Athletic Trainer. You may also see an Education Coordinator, if necessary.

What will happen during my appointment?
We will gather information on your injury, medical history, and relevant personal history that can impact recovery from concussion.

- We will do a neurobehavioral and physical examination which includes: neurological, oculomotor, and balance screenings.
- There will be no neuroimaging or invasive procedures.
- Neuropsychological or cognitive testing will be administered on a computer or tablet. There may be additional paper and pencil testing.
- Physical exertion testing, especially if you participate in athletics, regularly exercise, or have physical demands associated with your job.
- We will provide education on concussion and a treatment plan, as well as education or occupational accommodations, as needed.

Please note that the patient should not return to physical activity, including PE and recess, until evaluated and medically cleared by an appropriately trained healthcare professional with expertise in concussion management. If students are experiencing post-concussion symptoms, cognitive rest is just as important as physical rest, and your child's school should be notified about the concussion.

Information requested on this questionnaire is an important part of your child's evaluation and care. We appreciate you taking the time to fill it out fully, and carefully, and the highest standards of professional confidentiality are maintained. When consent to release information is granted, you may choose which information may/may not be released, and revoke that consent at any time.

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PATIENT DEMOGRAPHICS

Patient Name: _____ **DOB:** _____ **Sex:** ☐Male ☐Female

Address: _____

Home Phone: _____ **Cell:** _____ **Email:** _____

What is your preferred contact method? ☐Home phone ☐Cell phone ☐Email

Do you need an interpreter? ☐No ☐Yes- **Language?** _____

Who referred you to us? _____

CONCUSSION

Who is completing this form? _____ **What is your relationship to the patient?** _____

Date of Injury: _____ **Time of Injury:** _____ **Mechanism:** ☐Sports ☐MVA ☐Fall ☐Other

Tell us, in your own words, how the current injury happened:

_____

_____

_____

Did the patient lose consciousness? ☐No ☐Yes ☐Unsure **Do they remember what happened?** ☐No ☐Yes

Are there other factors that could be contributing to the patient's symptoms?

_____

Has this injury been treated? ☐No ☐Yes **By whom?** _____ **Has neuroimaging been done?** ☐No ☐Yes

Has the patient previously taken an ImPACT test? ☐No ☐Yes- **ImPACT Passport ID:** _____

Please list the dates and details of any previous concussions or brain injuries (estimate if unsure):

1. _____ 3. _____

2. _____ 4. _____

PAST MEDICAL & DEVELOPMENTAL HISTORY

Please select any condition(s) that the patient has been treated for:

☐ Headaches (pre-injury)
☐ Seizures
☐ Heart Problems
☐ Blood Disorders
☐ Diabetes/Hypoglycemia
☐ Urine/Bladder Problems
☐ Endocrine Disorder
☐ Motion Sickness/Sensitivity
☐ Seasonal Allergies
☐ Drug or Alcohol Use
☐ Speech/Language difficulties
☐ Learning Disability
☐ ADHD/ADD
☐ Special Education
☐ School Retention
☐ Anxiety
☐ Depression
☐ Mood or Behavior Problems
☐ Cutting or Self-harm
☐ Undiagnosed Learning or Attention Problems
☐ Check here if no history of anything listed

Please provide an explanation to any checked answer(s) above:

_____

_____

_____

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Did the patient have complications during birth or have early developmental delays? Select all that apply.

☐None ☐Early Fine Motor Skills ☐Speech/Language ☐School-related Learning ☐Separation Anxiety

When was the patient's last eye exam? _____ **Does the patient have vision difficulties?**

☐No ☐Glasses ☐Contacts ☐Astigmatism ☐Near-sighted ☐Far-sighted ☐Eye-tracking Problems

Does the patient take any medications? ☐No ☐Yes- Please list: _____

Are there any concerns about the patient's emotional functioning? ☐No ☐Yes

Has the patient received counseling or therapy in the past? ☐No ☐Yes

Does the patient have any sleep problems? ☐No ☐Yes

Please explain all "Yes" responses:

_____

_____

FAMILY HISTORY

(1) Parent: _____ **Age:** _____ **Education:** _____ **Occupation:** _____

(2) Parent: _____ **Age:** _____ **Education:** _____ **Occupation:** _____

Please list everyone (age & relationship) with whom the patient lives with (same or different households):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list any medical conditions within your biological family:

_____

_____

_____

How would you rate (1-10) the general level of stress at home, before the injury? _____

ACADEMIC HISTORY

School: _____ **Grade:** _____

Please list the patient's academic schedule (including lunch) in order:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

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Please select any that apply:

☐Homeschool/Online ☐Block Schedule ☐IEP ☐504 Plan ☐AP Courses ☐IB Courses ☐Not Currently in School

Typical grades: ☐A ☐B ☐C ☐D ☐F

Performance on standardized testing? ☐Below Average ☐Average ☐Above Average

Average amount of time spent on academic work per night: _____

List any upcoming (next 2-3 weeks) projects, papers, tests, etc.:

SOCIAL HISTORY

Does the patient participate in sports? ☐No ☐Yes **If so, what sport(s)?** _____

List any other extracurricular activities the patient participates in:

Does the patient work? ☐No ☐Yes **If so, where?** _____

Average amount of time spent (pre-injury) on screened devices (phone, computer, video games, TV, tablet) per night: _____

Would you describe the patient as: ☐Driven or Motivated ☐Easily Stressed ☐Perfectionistic

Does the patient have trouble "pulling back"? ☐No ☐Yes

Do you have any concerns about:

☐Behavior problems ☐Substance use ☐Social Stress or Bullying ☐Emotional functioning ☐None

Please describe any stressors or conflicts in the patient's life:

Please list any significant upcoming events (games, prom, travel, etc.):

Please list any other concerns, comments, or pertinent medical history: