Saponara Brain & Spine Center

Name: ____________________________

Date:_________________ Age: __________

Concussion/Mild Traumatic Brain Injury Intake Form

Please provide us with some information about your injury, if you do not understand a question, your therapist will assist you during the evaluation.

Date/Time of Injury:_______________ **Injury description**: ____

____

1b. Location of Impact: On the head- ☐ Front ☐ Left Front ☐ Right Front ☐ Left Back ☐ Right Back ☐ Back
Other location- ☐ Neck ☐ Body

2. Cause: ☐ Car accident ☐ Hit by a car ☐ Fall ☐ Assault ☐ Sports (specify)_____________ ☐ Other _________________

3. Are there any events just BEFORE the injury that you have no memory of (even brief)? ☐ Yes ☐ No Duration_____________

4. Are there any events just AFTER the injury that you have no memory of (even brief)? ☐ Yes ☐ No Duration_____________

5. Did you lose consciousness? ☐ Yes ☐ No Duration_____________

6. Early Signs: ☐ Dazed or stunned ☐ Confused about events ☐ Slow to respond ☐ Dizzy ☐ Forgetful ☐ Repeating things

7. Were seizures observed? ☐ Yes ☐ No If **yes**, please provide details____

8**. Did you receive medical attention at the time of the injury?** ☐ Yes ☐ No If **yes**, please explain, including any tests & results:

____

Since the injury, have you experienced <u>any</u> of these symptoms <u>more than usual</u> **today** or **in the past day**?

☐ Headache ☐ Fatigue ☐ Difficulty Concentrating ☐ Drowsiness ☐ Sleeping more than usual ☐ Nausea

☐ Sensitivity to light ☐ Difficulty remembering ☐ Trouble falling asleep ☐ Sleeping less than usual ☐ Vomiting

☐ Sensitivity to noise ☐ Irritability

☐ Balance Problems ☐ Numbness/tingling ☐ Sadness

☐ Dizziness ☐ Feeling mentally foggy ☐ More emotional

☐ Visual Problems ☐ Feeling slowed down ☐ Nervousness

<u>Exertion</u>: Do these symptoms <u>worsen</u> with:

Physical Activity ☐ Yes ☐ No ☐ N/A

Concentration/thinking ☐ Yes ☐ No ☐ N/A

Has anything like this ever happened in the past? ☐ Y ☐ N

If yes, how many times? 1 2 3 4 5 6+

What's the longest you experienced symptoms? ☐ Days ☐ Weeks ☐ Months ☐ Years

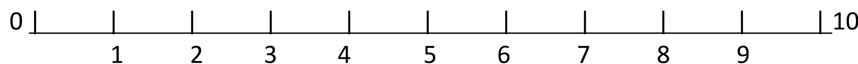
Vision	Headache (HA)	Developmental	✓	Psychiatric	✓
History of vision change or disturbance? ☐ Y ☐ N	Prior treatment for HA? ☐ Y ☐ N	Learning disabilities		Anxiety	
If yes, please explain: ________	History of migraine headache	ADD/ADHD		Depression	
______________________	☐ Personal ☐ Family	Other Developmental Disorder____________		Sleep Disorder	
	______________________			Other psychiatric disorder	

How do you learn best? By:

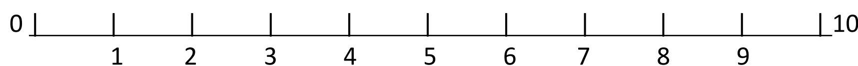
☐ Hearing it ☐ Reading it ☐ Seeing it demonstrated ☐ Performing it yourself ☐ Observing someone else

Rate your **<u>average pain</u>** or symptom on a scale of 0-10 with **"<u>0" equals to no pain</u>** and **"<u>10" equals the worst imaginable</u>.**

→ Mark the line at the point that represents your pain or symptom.



Rate how near you are to your **<u>normal function</u>** on a scale of 0-10 by with **"<u>0" equals not able</u>** to perform ***any*** of your normal activities and "**<u>10" equals able</u>** to do ***all*** normal activities without difficulty. → Mark the line at the point that represents your level of function.



Which skills or abilities do you hope to regain by coming to therapy? ______________________________________

<u>*PLEASE CONTINUE ON THE OTHER SIDE *</u>

Which of the following **over the counter medications** are you taking or have taken in the last week?

☐ Ibuprofen (Advil) ☐ Antihistamines ☐ Decongestants ☐ Naturopathic ☐ Vitamins ☐ Antacids

☐ Aspirin ☐ Laxatives ☐ Tylenol ☐ Naproxen Sodium (Aleve) ☐ Other: __________

Which of the following **prescription medications** are you taking?

☐ Allergy ☐ Hormones ☐ Pain ☐ Tone/Spasticity Reduction ☐ Other:____________

☐ Antibiotic ☐ Diabetes ☐ Reflux ☐ Cholesterol______________________

☐ Anti-inflammatory ☐ Depression ☐ Seizure ☐ Thyroid

☐ Blood Pressure ☐ Respiratory ☐ Anti-nausea ☐ Bladder

☐ Heart ☐ Muscle Relaxant ☐ Blood Thinners ☐ MS Med/Fatigue

Medical History:

☐ ADD/AHD
☐ Amputation
☐ Autism
☐ Auto Immune Disease:___________
☐ Balance Problems
☐ Bowel/Bladder Problems
☐ Cancer: ___________
☐ Cardiac Condition: ______________
☐ Chemical Dependency
☐ Chronic Otitis Media
☐ Cleft Palate
☐ Dementia
☐ Depression
☐ Diabetes
☐ Dizziness
☐ DVT's
☐ Failure to Thrive
☐ Falls
☐ Feeding/Swallowing Problems
☐ Fibromyalgia
Fractures: ______________
☐ Gastrointestinal: ______________
☐ Hepatitis
☐ Hearing Loss
☐ Headaches/Migraines
☐ High Blood Pressure (Hypertension)
☐ Labor/Delivery Complication
☐ Neurological Condition: ___________
☐ Noise Exposure
☐ Osteoarthritis
☐ Osteoporosis
☐ Psychological Condition: ___________
☐ Respiratory Condition: ___________
☐ Rheumatoid Arthritis
☐ Seizures
☐ Sleep disturbances
☐ Thyroid
☐ TMJ
☐ Vision
☐ Voice
☐ Other: ________________

Do you have any known allergies: Drug______________ Other ____________________

Social History:

1. Support system
   ☐ Married ☐ Single ☐ Widowed ☐ Significant other: _________________________

2. Living arrangement:
   ☐ Home/alone ☐ Home w/family ☐ Assisted living center ☐ Adult Foster home
   ☐ Children at home #:_________ Ages of Children_______________________

3. Amount of help currently needed at home:
   ☐ None ☐ Part of the day ☐ During the day ☐ During the night ☐ 24 hours a day

4. Home Accessibility:
   ☐ # of Stairs/Steps ☐ Walk-in Shower ☐ Rail ☐ Tub/shower combination

5. Assistive Devices/Equipment:
   ☐ Cane ☐ Bath bench ☐ Resting splints ☐ Walker ☐ Brace
   ☐ Raised toilet seat ☐ Commode ☐ Prosthesis ☐ Wheelchair/scooter ☐ Grab bars
   ☐ Hospital bed ☐ Dressing equipment ☐ Hearing aids ☐ Glasses ☐ Lifeline

Work History: Occupation:____

Current Status? ☐ Full duty ☐ Temporary disability ☐ Permanent disability ☐ Applied for disability

☐ Retired ☐ Volunteer ☐ Light duty ☐ Modified duty/job

☐ Restrictions are: ___________________________________

☐ Anticipated **return to work** date or work status change? ____

Physician follow-up: ☐ Physician recheck is scheduled for this date: _____________________