UnityPoint Clinic

Sports Medicine and Concussion Clinic

Information requested on this questionnaire is an important part of our evaluation that helps us to provide appropriate and individualized care.

Today's Date: _____ **Name of Person Completing Form if not the patient:** _____

DEMOGRAPHIC INFORMATION

Patient name and date of birth _____

Other physicians/specialists seen for this injury or illness AND those you routinely see, including therapists. **Please list phone & fax numbers:**

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

MEDICAL & DEVELOPMENTAL HISTORY

Dates of previous concussions / brain injuries (use best estimate if unsure) _____

	Patient diagnosed, treated or present	**Patient Suspected, not diagnosed**	**Patient's immediate family (siblings, parents, children)**
Headaches (pre-injury)			□ Yes □ No □ Don't know full history
Dementia or Alzheimers			□ Yes □ No □ Don't know full history
Seizures			□ Yes □ No □ Don't know full history
Anxiety			□ Yes □ No □ Don't know full history
Depression			□ Yes □ No □ Don't know full history
Other mood or behavior disturbance			□ Yes □ No □ Don't know full history
Seeing or hearing things that are not there			□ Yes □ No □ Don't know full history
ADHD / ADD			□ Yes □ No □ Don't know full history
Learning Disability			□ Yes □ No □ Don't know full history
Undiagnosed learning or attention problems			□ Yes □ No □ Don't know full history
Speech/Language Difficulties			□ Yes □ No □ Don't know full history
Held back a grade in school			□ Yes □ No □ Don't know full history
Tutoring/Special Education			□ Yes □ No □ Don't know full history
Trouble with the law			□ Yes □ No □ Don't know full history
Sleep apnea or restless leg syndrome			□ Yes □ No □ Don't know full history
Snoring			
Seasonal allergies			
Diabetes / Hypoglycemia			
Cutting or other self-harm			
PTSD or other personal trauma			
Excessive alcohol use			
Recreational drug use			
Smoking or vaping			
Double-jointed or hyper-flexible joints			
Eye-tracking problems			
Dizziness when standing too quickly			
Motion sickness			
Vision problems needing glasses or contacts			
Complications before, during or just after birth			
Any other unusual medical, learning, behavioral, or psychiatric difficulties not listed?			

Did you have any delays with early developmental milestones like sitting, walking, talking, toileting? □ No □ Yes

Current prescription medications: _____

Current over-the-counter pain medication (Tylenol/Advil etc) frequency: ☐ none ☐ few times/week ☐ most days daily ☐ multiple times/day

Any problems with sleep? (e.g., falling or staying asleep, waking up easily) □ no □ yes: _____

Average amount of sleep/night on weeknights _____ Does this seem to be enough to function well? □ no □ yes

FAMILY HISTORY

List all persons with whom you live full-time or part-time

Name	Age	Relationship	Name	Age	Relationship

General level of stress in the home, before the injury (Scale 1-10, 1=little, 10-extreme) _____

Describe any ongoing, significant family or other stressors or conflicts in your life? □ not applicable

_____

ACADEMIC HISTORY

Did you have any trouble learning how to read?	Yes	No
Did you like to read as a child?		
Do you read for pleasure now?		
Any trouble with spelling?		
Did you have any trouble learning a foreign language as a student?		
Did you have particular difficulty with timed tests in school?		
Did you ever need tutoring or any other kind of learning support?		

Reading/writing/literature/language arts: □ A's □ B's □ C's □ D's □ F's

Math □ A's □ B's □ C's □ D's □ F's

High school: □ did not graduate □ GED □ Diploma

College or Vocational training? □ Yes □ No

Training program or College Name	Years attended	Did you complete the program or finish your degree?	Major or area of study

WORK AND SOCIAL HISTORY

Current job / occupation: _____

How long have you been there? ____ months ____ years Number of hours/week typically work: _____

Briefly describe your job: _____

Do you routinely exercise? □ No □ Yes: how many days/week usually? _____ Which of the following do you do routinely – check all that apply: □ weightlifting □ running □ biking/skiing/other outdoor □ classes □ team sports □ yoga □ martial arts □ swimming □ ball sports with family/friends □ other _____

Any concerns about your emotional functioning? □ Yes □ No Concerns or history of suicidal/homicidal thoughts? □ Yes □ No

Would you or others characterize yourself as: □ "driven" □ easily stressed □ perfectionistic □ self-motivated □ self-starter □ None of these

When you were younger, did you have any social difficulties, including separating from your parents, making friends, bullying? □ No □ Yes

Are you satisfied with your current social life? □ no □ yes

Any history of counseling or psychotherapy? □ no □ yes

Total hours/day (average) spent watching TV, playing electronic games, text messaging, online social media, online chatting: _____

Please list any other concerns, pertinent medical history or general comments _____

_____

Any additional information you would prefer to share with us privately and not in writing on this form? □ No □ Yes

IF YOU ARE BEING SEEN IN CLINIC FOR A CONCUSSION, PLEASE ANSWER THESE ADDITIONAL QUESTIONS

Approximate amount of time you spend on computer screens during weekday _____

Describe the physical aspects of your job (lifting, standing, moving, etc.) _____

How many people in room where you work? _____ Natural light or artificial lighting in your work environment? _____

Have any workplace adjustments been made due to your symptoms? □ no □ yes

Have you missed any time from work due to this injury? □ no □ yes

Is your employer aware of this injury? □ no □ yes

Can you work from home? □ no □ yes

Do you have a lot of meetings? □ no □ yes

Do you like your job □ no □ yes

Is your work environment noisy? □ no □ yes

Can you take breaks on own schedule? □ no □ yes

Do you get interrupted a lot at work □ no □ yes

Date of last eye exam: _____ ☐ Normal vision ☐ Wears glasses or contacts

Are you or anyone else considering or involved with any legal action or a lawsuit related your concussion? □ no □ yes

I have provided complete, true, and accurate information to the best of my knowledge, since failure to do so will compromise clinical decision-making and care.

_____ _____

Signature Date