UnityPoint Clinic

Sports Medicine and Concussion Clinic
2901 86th Street
Urbandale, IA 50322
(515) 276-3406

BRIEF STUDENT HISTORY

(To be completed by parent/guardian for K-12 students if available)

Information requested on this questionnaire is an important part of our evaluation that helps us to provide appropriate and individualized post-injury care. For students on summer break or taking time off from school, list information as known for upcoming school year or term.

Today's Date: ________________ **Name of Person Completing Form:** ___________________________________

DEMOGRAPHIC INFORMATION

Patient Name: ____ Date of Birth: ___________ Grade: _____________

School: ____ Phone Number: _____________ Fax Number: ____________

Other physicians/specialists seen for this injury AND those routinely seen including therapists. **Please list phone and 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): ____

Does patient have any history of the following medical, developmental, or psychiatric issues that may impact the symptoms, duration and impact of a concussion? **Check here if no history of anything listed below:** ☐

Condition	Diagnosed or treated	Suspected, not diagnosed	Condition	Diagnosed or treated	Suspected, not diagnosed
Eye tracking problems			Dizziness if stands too quickly		
Headaches (pre-injury)			Speech/Language Difficulties		
Seizures			Held back a grade in school		
Anxiety			Social Skills / Social Stress		
Depression			Other mood or behavior disturbance		
ADHD/ADD			History of motion sickness		
Learning Disability			Hearing or seeing things not there		
Eating disorders			Cutting or other self-harm		
Seasonal allergies			School or legal discipline issues		
Vaping/tobacco use			Drug/Alcohol use		

Any other history of medical conditions, disorder, accidents, hospitalizations or surgeries:

Current prescription medications: ____

Current over-the-counter pain medication (e.g., Tylenol/Advil etc) and how often: ____

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

Sleep: Any pre-existing problems with sleep? (e.g., falling or staying asleep, waking up easily): ☐ No ☐ Yes

Average amount of sleep on school nights: ______ Does this seem to be enough to function well? ☐ No ☐ Yes

Any concerns about patient's emotional functioning? ☐ No ☐ Yes Concerns or history of suicidal/homicidal thoughts? ☐ No ☐ Yes

FAMILY HISTORY

Anyone in **biological** family with history of ☐ Behavior disorders ☐ Headaches/migraines ☐ Depression/other mood disorders Anxiety

☐ Learning/attention problems ☐ Sleep disorder ☐ NONE

Names of parents/legal guardians:

Parent/Guardian 1 ____________________ Age ____ Education ____________ Occupation ____________________

Parent/Guardian 2 ____________________ Age ____ Education ____________ Occupation ____________________

Was patient adopted? ☐ No ☐ Yes Does patient split time in different households? ☐ No ☐ Yes

List all persons with whom patient lives (in either the same or different households)

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 patient's life? ☐ not applicable

____

Are you considering or involved with any legal action or a lawsuit related to this injury? ☐ No ☐ Yes

WORK STATUS ☐ None

List any current jobs and hours/week): ____

Primary job duties: ____

Is work supervisor aware of the injury? ☐ No ☐ Yes Have any accommodations at work been made? ☐ No ☐ Yes

ACADEMIC AND SOCIAL HISTORY

Any concerns about grades/school/work? ☐ Before injury ☐ Since injury ☐ NONE

Typical grades: ☐ A's ☐ B's ☐ C's ☐ D's ☐ F's

Any pre-injury history of concerns or delays with: ☐ Spelling ☐ Reading ☐ Foreign-language Learning ☐ Math ☐ NONE

Any pre-injury history of: Tutoring ☐No ☐Yes School Accommodations ☐No ☐Yes 504 Plan ☐No ☐Yes IEP ☐No ☐Yes

Any history of Counseling or psychotherapy ☐ No ☐ Yes Any history of psychoeducational or psychological testing ☐ No ☐ Yes

If currently working with therapist: Name ___________________________________ Phone: ____________________

Fax: __________________________ Email: ____

Check the box that best represents typical performance on standardized testing:

	Very Superior 98 percentile +	Superior 91-97 percentile	High Average 75-90 percentile	Average 25-75 percentile	Below Average 9-25 percentile	Borderline below 9th
Reading:	☐	☐	☐	☐	☐	☐
Math:	☐	☐	☐	☐	☐	☐

Are teachers or other school personnel aware of the injury? ☐ No ☐ Yes

Have any adjustments or accommodations been made? ☐ No ☐ Yes

Average amount of time spent most nights on homework: __________

Upcoming exams, papers, projects over next 2-3 weeks (what, when due): ____________________________________
____

Upcoming standardized testing: ____

Are any current classes: ☐ on block schedule ☐ any AP? ☐ Any online? ☐ any IB? ☐ any advanced/honors?

If PSAT or ACT taken, provide score(s), estimate if unsure: ______________

List Current classes (Subjects) in order, including lunch

HIGH SCHOOL STUDENTS

Any AP or IB? ◻ Yes ◻ No

Any classes online? ◻ Yes ◻ No

COLLEGE STUDENTS

Also note the days on which your classes fall (M, Tu, W, Th, F)

Any classes online? ◻ Yes ◻ No

Average daily non-academic “screen time” (social media, video games, TV) BEFORE injury: ___________________

Extracurricular activities (what, how often): ____
____

Does patient drive: ☐ no ☐ learner’s permit ☐ licensed

Current Team Participation – Sport _______________________________ number practices/week __________________

Other exercise and physical activity: (what, how often): ____

Has the patient ever completed any computerized concussion “baseline testing” ☐ No ☐ Yes: **BRING TO APPOINTMENT**

Any upcoming travel plans (next 2-3 weeks): ____

Any other upcoming plans (e.g., prom, homecoming, etc.): ____

Would Parent characterize patient as: ☐ “Driven” ☐ Easily stressed ☐ Perfectionistic? ☐ Generally pretty relaxed, not a worrier

Does this patient typically have trouble “pulling back” or “letting go” ☐ No ☐ Yes

Any concerns about…. ☐ Behavior Problems ☐ Substance Use ☐ Social stress or bullying

____

____

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

____

Anything Parent would like to discuss with us privately, without patient present? ☐ No ☐ Yes

Anything Patient would like to discuss with us privately? ☐ No ☐ Yes

I have provided complete, true, and accurate information to the best of my knowledge. I also understand that information on this form, and any information provided as part of this evaluation/consultation, can be released only to individuals designated by me and with my written consent, and that my consent can also be revoked by me, in writing, at any time.

____ _________________________

Signature Date