Confidential Patient Information Form

Please complete the following questionnaire as fully and carefully as possible. Your answers will help us to process your file, determine the nature of your injury, and decide how best to assist you. This information will remain strictly confidential.

Total Balance PHYSIOTHERAPY

shift CONCUSSION MANAGEMENT PROGRAM CERTIFIED PROVIDER

Name: _____ Date of Birth: ____/____/_____
dd / mm/ yy

If Sport Related Injury /Concussion: Sport:_____ Team: _____

If this is related to a Motor Vehicle Accident – please indicate Date of Accident: _____

Injury Description/Complaint – Please give a brief description of your injury/Complaint (include how it happened)

When did symptoms start? _____

_____

_____

_____

Have you sustained any previous Concussions? ☐ No ☐ Yes If yes, indicate when they occurred and length of recovery:

_____

_____

Rate the following by circling a number:

Level of pain **now:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt

Level of pain **at its worst:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt

Is your pain: ☐ constant ☐ intermittent/random ☐ activity dependent ☐ not sure

Overall, is your pain getting ☐ better? ☐ worse? ☐ staying relatively constant?

Post-Concussion Symptom Scale: Please Indicate how you are feeling based on the **last 2 days:**

(do not need to fill out if you have done or are about to do ImPACT computer test)

0 = NONE; 1-2 = Mild; 3-4 = Moderate; 5-6 = Severe

Headache	0 1 2 3 4 5 6	Sensitivity to Noise	0 1 2 3 4 5 6
Nausea	0 1 2 3 4 5 6	Irritability	0 1 2 3 4 5 6
Vomiting	0 1 2 3 4 5 6	Sadness	0 1 2 3 4 5 6
Balance Problems	0 1 2 3 4 5 6	Nervousness	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	Feeling more Emotional	0 1 2 3 4 5 6
Fatigue	0 1 2 3 4 5 6	Numbness or Tingling	0 1 2 3 4 5 6
Trouble Falling Asleep	0 1 2 3 4 5 6	Feeling Slowed Down	0 1 2 3 4 5 6
Sleeping more than Usual	0 1 2 3 4 5 6	Feeling Mentally "Foggy"	0 1 2 3 4 5 6
Sleeping less than Usual	0 1 2 3 4 5 6	Difficulty Concentrating	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6	Difficulty Remembering	0 1 2 3 4 5 6
Sensitivity to Light	0 1 2 3 4 5 6	Visual Problems	0 1 2 3 4 5 6

Have you sought medical evaluation for your current complaint before now? ☐ Yes ☐ No

If yes, indicate type: ☐ Family MD ☐ Sport MD ☐ Emerge MD ☐ Walk-in MD ☐ Other_____

Have you had any imaging for your current complaint (X-ray, CT, MRI)? ☐ Yes ☐ No

Do any of the conditions below apply to you? ☐ None

☐ ADHD ☐ Depression ☐ Migraine ☐ Learning Disability ☐ Sleep Disorder ☐ Anxiety

Do you experience spells of vertigo (vertigo = do you perceive the environment around your moving)? YES NO

If YES, how long do these spells last? _____ When was the last time the vertigo occurred? _____

Is the vertigo: Spontaneous YES NO Induced by motion YES NO

Induced by position changes YES NO

Do you experience a sense of dizziness (spinning in your head but your surroundings stay stable) or a sense of being **off balance** (disequilibrium)? YES NO

If YES, is the feeling of dizziness/being off-balance:

Constant	YES	NO	Worse with Fatigue	YES	NO
Spontaneous	YES	NO	Worse outside	YES	NO
Induced by motion	YES	NO	Worse in the dark	YES	NO
Induced by position changes	YES	NO	Worse on uneven surfaces	YES	NO

If YES, does the feeling of dizziness or being off-balance occur when you are:

Lying Down	YES	NO	Sitting	YES	NO
Standing	YES	NO	Walking	YES	NO

Do you OR have you fallen (to the ground) YES NO

If yes, please described? _____

How often do you fall? _____

Have you injured yourself? _____

Do you stumble, stagger, or side-step while walking? YES NO

Do you drift to one side while you walk? YES NO

If yes, which side do you drift? Right Left

Do you have neck/back problems? YES NO If YES, to any describe:

Do you have any hearing or visual problems? YES NO

Have you had a routine eye exam in the last year? YES NO

<u>Social History:</u>

Do you live alone? YES NO

Do you have stairs in your home? YES NO

Do you have trouble sleeping? YES NO

<u>Functional Status:</u>

Are you independent in self-care activities? YES NO

Can you drive……in the daytime? YES NO In the night time? YES NO

Are you working? YES NO

Are you on Medical Disability? YES NO

Are you able to:

Watch TV comfortably	YES	NO	Read	YES	NO
Go shopping	YES	NO	Be in traffic	YES	NO
Work on a computer	YES	NO	Be in a noisy place	YES	NO

Are you currently experiencing any ongoing medical conditions, or have had any previous health concerns (surgeries, hospitalizations, fractures or traumas) that we have not yet covered or asked?

Is there a family history (immediate family) of Heart Disease, High Blood Pressure, Cancer, Stroke, or Other Disease?_____

_____