ADVANCE CONCUSSION CLINIC® Play Hard. Play Safe.™

Affix Patient Label Here

Injury History **Date of Injury:** _____

1. Injury Description _____

_____

2. Was there evidence of injury? ☐ Yes ☐ No ☐ Unknown

3. Was there imaging (i.e. CT, MRI) done? If yes, please attach reports/imaging. ☐ Yes ☐ No Type_____

4. Cause: ☐ MVA ☐ MVA v. Pedestrian ☐ Fall ☐ Assault ☐ Sports or Other (*specify)* **Loss of Consciousness:** ☐ Yes If yes, duration _____ ☐ No ☐ Unknown

Seizures: Were seizures observed? ☐ Yes If yes, details _____ ☐ No ☐ Unknown

Patient's Primary Complaint: _____

Risk Factors:

Concussion History? *(circle one)* **Y N**	**Developmental History**
If yes, specify#:_____	Learning Disabilities
Headache History? *(circle one)* **Y N**	ADHD
Patient _____ Family _____	Other developmental disorder
Anxiety	**Sleep Disorder?** *(circle one)* **Y N**
Depression	Please specify
Other _____	If yes, what treatment if any

List other medical conditions and all current medications (e.g., hypothyroid, diabetes)

_____

_____

Physician Comments/Referral Specific Questions:

Diagnosis: Concussion ☐ Yes ☐ No ☐ Other _____

Upcoming Medical Investigations/Tests: _____

Best practice is interdisciplinary treatment for concussion.

Opt out of: ☐ OT ☐ PT ☐ AT ☐ CC Reasons _____

Physician Signature:

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