

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 any of these symptoms more than usual 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

Exertion: Do these symptoms worsen with:

Physical Activity Yes No N/A

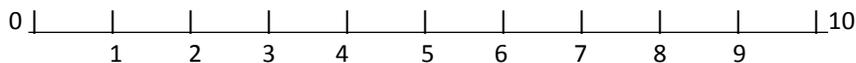
Concentration/thinking Yes No N/A

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

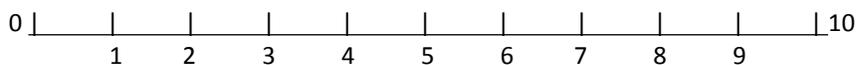
Vision	Headache (HA)	Developmental	✓	Psychiatric	✓
History of vision change or disturbance? <input type="checkbox"/> Y <input type="checkbox"/> N	Prior treatment for HA? <input type="checkbox"/> Y <input type="checkbox"/> N	Learning disabilities		Anxiety	
If yes, please explain: _____	History of migraine headache	ADD/ADHD		Depression	
_____	<input type="checkbox"/> Personal <input type="checkbox"/> 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 average pain or symptom on a scale of 0-10 with **"0" equals to no pain** and **"10" equals the worst imaginable**.
→ Mark the line at the point that represents your pain or symptom.



Rate how near you are to your normal function on a scale of 0-10 by with **"0" equals not able** to perform **any** of your normal activities and **"10" equals able** 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? _____

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