DUKE SPORTS MEDICINE CONCUSSION EVALUATION

Patient Name: ____ Duke MR# _________________
DOB: ______________ Age: ______ Date: ________________
School: ____

Injury Characteristics:
Date/Time of Injury ______________________ Reporter: Patient___ Parent___ Spouse___ Other ___

Injury Description ____

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(Check all that apply)
a. Is there evidence of a forcible blow to the head (direct or indirect)? __Yes __No __Unknown
b. Is there evidence of intracranial injury or skull fracture? __Yes __No __Unknown
c. Location of impact: ___Frontal ___Left Side ___ Right Side ___Back ___Neck ___Indirect Force

Cause ___MVC ___Pedestrian/MVC ___Fall ___Assault ___Sports (*Specify*)______________________
Amnesia Before Are there any events just BEFORE the injury that you/person has no memory of even briefly? ___Yes ___No _____________Duration
Amnesia After Are there any events just AFTER the injury that you/person has no memory of even briefly? ___ Yes ___ No _____________Duration
Loss of Consciousness Did you/person lose consciousness ___ Yes ___ No ______________Duration
Early Signs ____Appears dazed or stunned ___Is confused about events ___Answers questions slowly ____Repeats questions ___Forgetful (recent information)
Seizures Were seizures observed? ___No ___Yes Details_____________________________________

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Risk Factors for Protracted Recovery (*Check all that apply)*

History of Previous Concussions? Yes___ No___
How many: 1___2___3___4___5___6+___
Longest symptom duration: Days___Weeks___Months___Years___
If multiple concussions, did less force cause reinjury? Yes___ No___

History of Headaches? Yes___ No___
Prior treatment for headache Yes___ No___
History of migraine headache
Personal ____ or Family ____

Developmental History
Learning disabilities Yes____ No____
ADD/ADHD Yes____ No____
Other developmental disorder Yes____ No____

Psychiatric History
Anxiety ____ Depression ____ Sleep disorder ____ Other psychiatric disorder ____

List other comorbid medical disorders or medication usage (e.g., hypothyroid, seizures) ________________________________

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SYMPTOM EVALUATION – How Do You Feel?
You should score yourself on the following symptoms, based on how you feel:

	Symptoms **NOW**							Symptoms @ **TIME OF INJURY**						
	None	Mild		Moderate			Severe	None	Mild		Moderate			Severe
Headache	0	1	2	3	4	5	6	0	1	2	3	4	5	6
"Pressure in Head"	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Neck pain	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Trouble falling asleep (if applicable)	0	1	2	3	4	5	6	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Nervous or anxious	0	1	2	3	4	5	6	0	1	2	3	4	5	6

Symptom Score Total __________ Now __________ Time of Injury

Do the symptoms get worse with physical activity? Yes ____ No_____
Do the symptoms get worse with mental activity? Yes _____ No _____

Overall Rating

If you know the athlete well prior to the injury, how different is the athlete acting compared to his/her usual self? *Please circle one response*: No different Very different Unsure