Concussion Intake Form

This information will remain strictly confidential.

PERSONAL INFORMATION

File Number: __________________ Name:_____________________________ Date of Birth: ____/____/_____

Age:_____ M/F Height: ____________________ Weight:_________________ Handiness: L/R

Address:________________________ City:_________________________ Postal Code: ____________

Telephone: (home) ________________________ (work and/or cell) ____________________________

Email: ________________________________ Native Country:___________________

Native Language: ___________________________ Second Language: _______________________

Emergency Contact: (name/relation) ________________________ (Tel) __________________________

Current Occupation: _______________________________

Name of Medical Doctor: _____________________________ (Tel) ____________________________

Sport & Health History

Years of education: _______________ What type of student are/were you? Below Average Average Above Average

Have you ever:

Received speech therapy: Y/N

Attended Special Education Classes: Y/N

Repeated 1 or more years of school: Y/N

Been Diagnosed with a learning disability: Y/N

Been Diagnosed with ADD or Hyperactivity: Y/N

What is your current Sport:____________________________ Position:_____________________

Team: ___________________________________ Level: ________________________ Years playing at this level: ___

How were you referred to the Shift Concussion Management Program? ____

How many times have you been diagnosed with a concussion: ___ How many resulted in:

Loss of consciousness: ___ Confusion:___ Memory loss immediately after:____ Memory loss immediately before:__

Total number of games missed for ALL concussions:______

Please list your 5 most recent concussions:

MONTH	YEAR

Have you ever received treatment for/been diagnosed with:

Headaches: Y/N Migraines: Y/N Epilepsy/seizures: Y/N Meningitis: Y/N Substance/Alcohol: Y/N

Psychiatric condition (anxiety/depression: Y/N ADD/ADHD: Y/N Dyslexia: Y/N Autism: Y/N

Please list any medications, or supplements (e.g. vitamins) you are currently taking (including over-the-counter):

____

Are you currently experiencing any ongoing medical conditions not listed?_____________________________

Have you participated in strenuous activity within the last 3 hours? Y/N

What is the date your last/current concussion was sustained?_________________________

How many hours did you sleep last night? ___________________

POST CONCUSSION SYMPTOM SCALE

Please Indicate how you are feeling based on the **last 2 days:**

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

Symptom	Rating	Symptom	Rating
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
Dizziness	0 1 2 3 4 5 6	Sadness	0 1 2 3 4 5 6
Vomiting	0 1 2 3 4 5 6	Numbness or Tingling	0 1 2 3 4 5 6
Balance Problems	0 1 2 3 4 5 6	Feeling Nervous	0 1 2 3 4 5 6
Trouble Falling Asleep	0 1 2 3 4 5 6	Feeling Emotional	0 1 2 3 4 5 6
Fatigue	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	Feeling too Slow	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6	Memory Problems	0 1 2 3 4 5 6
Sleeping more than Usual	0 1 2 3 4 5 6	Difficulty Concentrating	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

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

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 (Xray, CT, MRI)? ☐ Yes ☐No

Are you currently experiencing any ongoing medical conditions not listed?_____________________________

Have you had a routine eye exam in the last year? ☐No ☐Yes

INJURY/DESCRIPTION OF COMPLAINT

Give a Brief Description of your Injury/Complaint (Include how it was sustained):

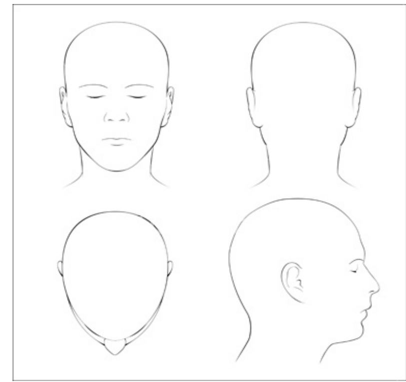
____
____
____

Date of Injury/Symptom Onset: __________________

Dr. Sheldon Campbell, B.S.c., D.C. & Dr. Matthew McKeagan, B.Kin., D.C. 208-1002 Beaverbrook Rd Kanata, Ontario K2K 1L1 Phone: 613-592-8656

For Head/Neck Pain:

On the drawings to the right, please mark painful areas with symbols given:



X Sharp & Stabbing	△ Burning	∿∿ Pins & Needles
S Dull Ache	○ Numb	═ Stiff & Tight
☆ Pressure	# Throbbing	

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

PAST HEALTH HISTORY

Please indicate any previous **surgeries, hospitalizations, fractures, or traumas (other than concussion)** (include year):

____

____

____

FAMILY HEALTH HISTORY

Have you or anyone in your immediate family had any of the following (please check those that apply):

☐Heart disease ☐High blood pressure ☐Cancer ☐Diabetes ☐Stroke ☐Other Disease

____

PLESE REVIEW BELOW, SIGN AND RETURN

I hereby consent to the administration and supervision of a concussion assessment by *Shift Concussion Management.*

_______________________________ _______________________________

Signature of Participant/Guardian **Date**

_______________________________ _______________________________

Witness Signature **Date**

Campbell Chiropractic of Kanata

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Kanata, Ontario

K2K 1L1

Phone: (613) 592-8656 Fax: (613) 592-6677

Vision Questionnaire

File Number: ________________ **Name:**_______________________________ **Date of Birth:** ____/____/_____ **M/F**

Please mark off the appropriate box below, legal guardian of patients under 12 should fill this in for the patient.

	Never	Not Often	Sometimes	Fairly Often	Always
Do your eyes feel tired when reading or doing close work?					
Do your eyes feel uncomfortable when reading?					
Do you experience headaches while reading?					
Do you feel sleepy when reading?					
Do you lose concentration when reading?					
Do you have trouble remembering what you read?					
Do you have double vision when reading?					
Do you see words move or jump when you read?					
Do you feel like you read slowly?					
Do your eyes ever hurt when reading?					
Do your eyes ever feel sore (i.e. achy) when reading?					
Do you ever feel a “pulling feeling” around your eyes?					
Do you notice words coming in and out of focus?					
Do you lose your place/line when reading?					
Do you re-read the same line when reading?					
Multiply total score by a factor of:	**X0**	**X1**	**X2**	**X3**	**X4**
Add scores in the boxes to the right:					

Please mark off the appropriate box below, legal guardian of patients under 12 should fill this in for the patient.

	Never	Not Often	Sometimes	Fairly Often	Always
Do you ever feel dizzy or off balance?					
Do you feel nausea if you change posture quickly?					
Do you get motion sickness?					
Do you tend to “drift to one side” when walking?					
Do you get panic attacks?					
Do you get symptoms of depression?					
Do you take pain medications?					
Do you feel unsafe driving?					
Do you feel as though you get visually fatigued quickly?					
Do you have trouble with short term memory?					
Do you bump into things unexpectedly?					
Do you get double vision?					
Does your vision tend to fluctuate in terms of clarity?					
Are you light sensitive?					
Do you have problems watching 3D movies?					
Multiply total score by a factor of:	**X0**	**X1**	**X2**	**X3**	**X4**
Add scores in the boxes to the right:					

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