Baseline Consent Form

shift CONCUSSION MANAGEMENT PROGRAM
CERTIFIED PROVIDER

Campbell Chiropractic OF KANATA

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: _____ Team Affiliation (if Applicable): _____

Emergency Contact: (name/relation) _____ (Tel) _____

Family Doctor: _____ (Tel):_____

CONFIDENTIAL MEDICAL INFORMATION AND CONCUSSION HISTORY

Please complete the following questions as fully and carefully as possible in order to help us effectively interpret the results of your baseline assessment. This information will remain strictly confidential.

Concussion History: include month/year, how it happened, symptoms experienced, and length of recovery:

☐No known concussions

_____

_____

_____

_____

_____

Do any of the following conditions apply? (please indicate)

☐ADD/ADHD ☐Clinical Depression/Anxiety ☐Migraine Headaches ☐Learning Disability ☐Sleep Disorder

☐Dyslexia ☐Repeated one or more grade levels ☐Received speech therapy

☐Individual Education Plan (IEP) ☐Motion Sickness / Car Sickness ☐Visual Condition: _____

Please indicate your level of academic performance:

☐Below average (C/D Student) ☐Average (B/C Student) ☐Above Average (A/B Student)

PLEASE REVIEW BELOW, SIGN, AND RETURN

I hereby consent to the administration and supervision of a concussion baseline test by *Shift Concussion Management*. I understand that baseline testing does not prevent concussive injuries, but allows healthcare professionals to better manage the injury should it occur.

_____ _____ _____

SIGNED PRINT NAME DATE

For patients under the age of 16: PLEASE HAVE PARENT/GUARDIAN SIGN ABOVE*

Dr. Sheldon Campbell, B.S.c., D.C. & Dr. Matthew McKeagan, B.Kin., D.C.
1002 Beaverbrook Rd., Suite 208, Kanata, ON, K2K 1L1 Phone: (613) 592-8656 Fax: (613) 592-6677

Vision Questionnaire

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

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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