Baseline Demographic & Background Information

School: ___________________________________

Name: __________________________________ Address: ____

Date of Birth (mm/dd/yy): _____________ Gender: M / F Height: _____________ Weight: ________

Handedness: R / L / Ambidextrous (both R & L) Native Country: ______________________

Native Language: ________________________ Second Language (only if fluent in reading and writing) _____________________

Years of education completed excluding kindergarten: ________ (e.g., individual who is going to be a high school senior is 11)

Check any of the following that apply:

Received Speech Therapy   Attended special education classes   Diagnosed learning disability

Repeated one or more years of school   Diagnosed ADD/ADHD

While in school, what type of student are you? Below average   Average   Above average

Current sport/activity: Baseball/Softball   Basketball   Track   Cheerleading   Volleyball   Marching Band

Current position/event: ______________________________ (e.g., quarterback, forward, sprinter, etc.)

Current level of participation: Grade School   Junior High/Middle School   **Years of experience at this level:** _______

Please list your 2 most recent concussions:

______ month ______ year

______ month ______ year

Concussion History: (Please mark N/A if not applicable)

______ Number of times diagnosed with a concussion

______ Total # of concussions

______ Total # of concussions that resulted in confusion

______ Total # of concussions that resulted in difficulty with memory for events that occurred immediately after injury

______ Total # of concussions that resulted in difficulty with memory for events that occurred immediately before injury

______ Total # of games that were missed as a direct result of all concussions combined

Indicate if you have had any of the following: (Please circle Y for yes and N for no)

Y / N Treatment for headaches by physician   Y / N Treatment for migraine headaches by a physician

Y / N Treatment for epilepsy/seizures   Y / N Treatment for brain surgery

Y / N Treatment for meningitis   Y / N Treatment for substance abuse / alcohol abuse

Y / N Treatment for psychiatric condition (depression/anxiety)

Have you been diagnosed with any of the following? (Please circle Y for yes and N for No)

Y / N ADD/ADHD   Y / N Dyslexia   Y / N Autism

Date of your last concussion (mm/dd/yy): ________________________

Please list any **prescription** medication you are currently taking: ____

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