KINETIC PHYSICAL THERAPY
adolescent sports medicine

Post Concussion Evaluation Form

Name:_____ **Date:**_____

Age:_____ Sex: M F Height: _____ Weight: ____ Dominant hand: R L

SCHOOL INFORMATION: Grade:_____ School:_____

WORK INFORMATION: Do you have a job: Y N If yes, job: _____

SPORT INFORMATION: Current sport(s) and/or activities: _____

Position(s) played:_____ How long have you been playing:_____

HISTORY OF INJURY: How did your problem occur?:_____

_____

Date of Onset:_____ Involved Side: R L Both Next Physician Follow-up:_____

Loss of consciousness: Y N Nausea/vomiting: Y N Memory loss: Y N

Describe any previous problems with this area: _____

MEDICAL INFORMATION: Family Physician:_____

Referring Physician:_____ Diagnosis: _____

Medical Tests: X-Ray ___CT Scan ___Bone Scan ___MRI ___EMG ___Nerve Conduction_____

Arthrogram___ ImPACT___ Other:_____Results:_____

Did you use: Cast ____Splint___ Brace___ Date Applied:___/___/____ Date Removed___/___/____

Do you drink or smoke: Y N **Females:** Have you started menstruating? Y N Age of first period: ___

Have you ever been diagnosed with any of the following conditions?

__Y	__N	Cancer	__Y	__N	Juvenile Rheumatoid Arthritis
__Y	__N	Heart or Circulation Problems	__Y	__N	Other Arthritic Conditions
__Y	__N	High Blood Pressure	__Y	__N	Hepatitis
__Y	__N	Depression/Anxiety/OCD	__Y	__N	Stroke
__Y	__N	Asthma	__Y	__N	Latex Allergy
__Y	__N	Allergies	__Y	__N	Anemia
__Y	__N	Eating Disorder	__Y	__N	Osteoporosis/Osteopenia/Stress fractures
__Y	__N	Thyroid Problems	__Y	__N	Multiple Sclerosis
__Y	__N	Diabetes	__Y	__N	Learning disability
__Y	__N	Lyme's Disease	__Y	__N	Concussion

Please turn over and complete the other side

List any medications (including prescriptions, over-the-counter, herbals, vitamin/mineral/dietary supplements) you are currently taking:

	Name of Med./Supplement	Dosage	Frequency of Use	Route of Administration
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

FUNCTION:

Indicate any activities that you have difficulty completing (walking, sitting, running, standing, climbing stairs, sports, school, lifting, carrying, driving, position changes, reading, computer use, throwing, squatting, cutting, pivoting, jumping, sleeping, dressing, reaching):

_____

What are your goals for Physical Therapy? _____

SYMPTOMS: (select your symptom level from the following number OR face scales)

Circle the amount of your symptoms at rest- (No Pain)0 1 2 3 4 5 6 7 8 9 10 (Unbearable)
Circle the amount of your symptoms with activity- (No Pain)0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Are your symptoms: Constant____ Intermittent____

Symptoms: Headache Dizziness Disorientation Nausea/vomiting Imbalance

Memory loss Hearing Loss Vision changes Other

Since onset, symptoms have: Improved Worsened No change Other

Activities that increase symptoms:_____
Activities that decrease symptoms:_____

Please mark on the drawing and/or lists below the areas where you feel your pain:

Head/neck: Y N
Upper/mid back: Y N
Low back: Y N
Shoulders: Y N
Elbows: Y N
Wrists/hands: Y N
Hips: Y N
Knees: Y N
Ankles/feet: Y N
Other: Y N