

## Demographic and Background Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_Month \_\_\_\_\_Date \_\_\_\_\_Year

Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Have you ever been diagnosed with attention deficit disorder or hyperactivity? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever been diagnosed with a learning disability? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you had a concussion in the last 6 months? \_\_\_\_\_ Yes \_\_\_\_\_ No

Years of education completed excluding kindergarten: \_\_\_\_\_

(e.g., high school senior is 11 years)

Check any of the following that apply:

- \_\_\_\_\_ Received speech therapy
- \_\_\_\_\_ Attended special education classes
- \_\_\_\_\_ Repeated one or more years of school

While in school, what type of student were / are you?

\_\_\_\_\_Below Average \_\_\_\_\_Average \_\_\_\_\_Above Average

Current Sport: \_\_\_\_\_

Current position / event / class: \_\_\_\_\_

(e.g., quarterback, forward, 1st base, etc.)

Current level of participation: \_\_\_\_\_(e.g., junior high, high school)

Years of experience at this level: \_\_\_\_\_ (0 - 4)

(e.g., number of years in high school, high school senior = 3)

### Concussion History

- \_\_\_ Number of times diagnosed with a concussion (excluding current injury)
- \_\_\_ Total number of concussions that resulted in loss of consciousness
- \_\_\_ Total number of concussions that resulted in confusion
- \_\_\_ Total number of concussions that resulted in difficulty with memory for events that occurred immediately after injury
- \_\_\_ Total number of concussions that resulted in difficulty with memory for events that occurred immediately before injury
- \_\_\_ Total number a games that were missed as a direct result of all concussions combined

Indicate whether you have been treated for the following:

- \_\_\_ Yes \_\_\_ No      Headaches by physician
- \_\_\_ Yes \_\_\_ No      Migraine headaches by physician
- \_\_\_ Yes \_\_\_ No      Epilepsy / seizures
- \_\_\_ Yes \_\_\_ No      Brain surgery
- \_\_\_ Yes \_\_\_ No      Meningitis
- \_\_\_ Yes \_\_\_ No      Substance abuse / alcohol abuse
- \_\_\_ Yes \_\_\_ No      Psychiatric condition (depression, anxiety)

Have you been diagnosed with any of the following?

- \_\_\_ Yes \_\_\_ No      Dyslexia
- \_\_\_ Yes \_\_\_ No      Autism

Have you participated in any strenuous exercise and/or exertion in the last three hours? \_\_\_ Yes \_\_\_ No

Date of your last concussion: \_\_\_\_\_ month \_\_\_ date \_\_\_ year

Hours of sleep last night (approximate if uncertain): \_\_\_\_\_

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