Clinical Concussion Intake Form

Demographics

Name: First_____ Last_____

Name you would like to be called _____

Address _____ **City**_____ **State**_____
Zip Code_____

Phone: _____ **Email**_____

DOB _____ **Gender** ❑ M ❑ F

Marital Status ❑ Single ❑ Married ❑ Divorced ❑Widowed ❑Separated ❑Partner

Primary Care Physician_____ **Who Referred You** _____

Have you received treatment for this injury/complaint? ❑ Yes ❑ No

Social History

Who do you live with? _____ **Number of members in household**_____

How many stairs/steps do you have to negotiate? _____ **How many levels are in your home?**_____

Handedness ❑Left ❑ Right ❑Both

I am a (check all that apply):

❑Student Where? _____ Grade/Level_____

❑Working Occupation_____ Hours/week_____

❑Stay at home parent ❑Unemployed ❑Disabled ❑Retired

Do you smoke? ❑ Y ❑ N Packs per day _____

Do you drink alcohol? ❑Y ❑ N Drinks per week_____

Do you use illicit drugs? ❑Y ❑ N If yes, how frequently? _____

Sports/Athletic Activities_____ **Hours per week?**_____

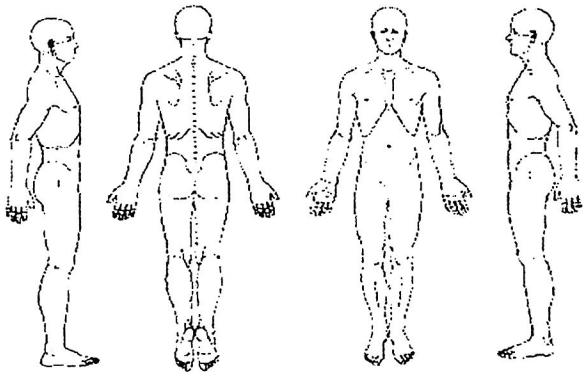
Level of Participation ❑Professional ❑Collegiate ❑ High School ❑Recreational ❑Other_____

During the past month have you been feeling down, depressed or hopeless? ❑Y ❑ N

During the last month have you been bothered by having little interest in doing things? ❑Y ❑ N

Pain Rating:

Please place an arrow of where your head was impacted during the injury. ➔



Body Chart:

Please mark the location of your pain and the type of pain on the chart:

KEY:

X Sharp stabbing pain

O Dull achy pain

..... Numb/Tingling

/// Throbbing

^^^ Burning

Pain at its Lowest	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable pain
Pain Currently	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable pain
Pain at its Worst	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable pain

Past Medical History

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

- ❑cancer
- ❑heart disease
- ❑high blood pressure
- ❑asthma
- ❑pacemaker
- ❑osteoporosis
- ❑chemical dependency(alcoholism)
- ❑rheumatoid arthritis
- ❑stroke
- ❑depression
- ❑anemia
- ❑lung problems
- ❑thyroid problems
- ❑osteoarthritis
- ❑diabetes
- ❑multiple sclerosis
- ❑kidney/liver problems
- ❑stomach ulcers/GERD
- ❑epilepsy
- ❑Parkinson's disease
- ❑other_____

Please list any surgeries and/or hospitalizations you have had_____

Have you ever been diagnosed with: ❑learning disability/dyslexia ❑ADD/ADHD ❑seizure disorder ❑Migraine headache ❑anxiety, depression, or any psychiatric condition

Please list current medications that you are taking? _____

Injury

Date of most recent concussion ___/___/_____ **Have you ever had a previous concussion?** ❑ Y ❑ N

Please describe how your recent injury occurred

_____

The injury was a result of: ❑ a collision with another person/player ❑a collision with the ground

❑ a collision with a piece of equipment/object ❑non-contact trauma (whiplash)

Did you receive medical treatment after injury? ❑Y ❑ N **If so, what kind?** _____

On the day of your injury did you continue to play/work/participate in activity? ❑Y ❑ N

Were you wearing a helmet? ❑ Y ❑ N ❑NA

Have you continued to exercise since your injury? ❑ Y ❑ N

Did you lose consciousness? ❑ Y ❑N **How long?**_____

Have you lost memory of events which occurred BEFORE your injury? ❑ Y ❑N

Have you lost memory of events which occurred AFTER your injury? ❑Y ❑N

Have you had the following? ❑Brain MRI ❑Cervical Spine MRI ❑Brain CT ❑Skull or Cervical Spine X-ray

❑Neuropsychological Testing ❑ImPACT Test, when?_____

Are you still able to go to school/work? ❑Y ❑ N **How many hours?**_____ ❑ NA

Are classes/job more difficult for you? ❑Y ❑N ❑NA

Has your mood changed? ❑ Y ❑ N

Is it more difficult to spend time with friends and family? ❑ Y ❑ N

If you answered yes to any questions above please explain:_____

_____

How many hours of sleep are you currently getting? _____

Are you able to read without increase in symptoms? ❑ Y ❑ N

Does computer work aggravate symptoms? ❑Y ❑ N

Are you able to ride in a car? ❑ Y ❑N **Are you currently driving?** ❑Y ❑ N

Learning/Environmental Factors:

Do you wear corrective lenses? ❑Y ❑ N **Date of last eye exam?** ___/___/_____

How do you learn best? (check all that apply) ❑visual ❑ auditory ❑demonstration ❑ written

Do you currently receive any special services/therapy/nursing? ❑Y ❑N **If yes, what?**_____

Are you able to perform all your self-care activities independently? ❑Y ❑ N

Are there any special cultural and/or religious concerns you would like to share or be considered during treatment?

_____

Thank you for completing the questionnaire, it will aid in gaining a clear picture of your symptoms and limitations since your injury.

POST CONCUSSION SYMPTOM SCALE

Directions: After reading each symptom, please circle the number that best describes the way you have been feeling **TODAY**. Please answer the sleep rated questions for **last night**. A rating of 0 means you have not experienced this symptom **TODAY.** A rating of 6 means that you have experienced severe problems with this symptom today.

Dates of Last known Concussion

Symptom		None	Mild (1-2)		Moderate (3-4)		Severe (5-6)	
Headache		0	1	2	3	4	5	6
Nausea		0	1	2	3	4	5	6
Vomiting		0	1	2	3	4	5	6
Balance Problem		0	1	2	3	4	5	6
Dizziness		0	1	2	3	4	5	6
Fatigue		0	1	2	3	4	5	6
Trouble falling Asleep		0	1	2	3	4	5	6
Sleeping more than usual		0	1	2	3	4	5	6
Sleeping less than usual		0	1	2	3	4	5	6
Drowsiness		0	1	2	3	4	5	6
Sensitivity to light		0	1	2	3	4	5	6
Sensitivity to noise		0	1	2	3	4	5	6
Irritability		0	1	2	3	4	5	6
Sadness		0	1	2	3	4	5	6
Nervousness		0	1	2	3	4	5	6
Feeling more emotional		0	1	2	3	4	5	6
Numbness or tingling		0	1	2	3	4	5	6
Feeling slowed down		0	1	2	3	4	5	6
Feeling mentally "foggy"		0	1	2	3	4	5	6
Difficulty concentrating		0	1	2	3	4	5	6
Difficulty remembering		0	1	2	3	4	5	6

For Office Use Only

Total Symptom Score:

Grand total of all Symptoms_____

HIT-6™ Headache Impact Test

HIT is a tool used to measure the impact headaches have on your ability to function on the job, at school, at home and in social situations. Your score shows you the effect that headaches have on normal daily life and your ability to function. HIT was developed by an international team of headache experts from neurology and primary care medicine in collaboration with the psychometricians who developed the SF-36® health assessment tool. This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.

When you have headaches, how often is the pain severe?

never rarely sometimes very often always

How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

never rarely sometimes very often always

When you have a headache, how often do you wish you could lie down?

never rarely sometimes very often always

In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

never rarely sometimes very often always

In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

never rarely sometimes very often always

In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

never rarely sometimes very often always

☐	☐	☐	☐	☐
COLUMN 1 6 points each	COLUMN 2 8 points each	COLUMN 3 10 points each	COLUMN 4 11 points each	COLUMN 5 13 points each

To score, add points for answers in each column.

If your HIT-6 is 50 or higher:

You should share your results with your doctor. Headaches that stop you from enjoying the important things in life, like family, work, school or social activities could be migraine.

☐
TOTAL SCORE

Patient Name: _____ Date: _____

The Activities-specific Balance Confidence (ABC) Scale*

Instructions to Participants: For each of the following activities, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale from 0% to 100% If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports.

0%	10	20	30	40	50	60	70	80	90	100%
No Confidence										Completely Confident

How confident are you that you will not lose your balance or become unsteady when you...

1. ...walk around the house? _____%
2. ...walk up or down stairs? _____%
3. ...bend over and pick up a slipper from the front of a closet floor? _____%
4. ...reach for a small can off a shelf at eye level? _____%
5. ...stand on your tip toes and reach for something above your head? _____%
6. ...stand on a chair and reach for something? _____%
7. ...sweep the floor? _____%
8. ...walk outside the house to a car parked in the driveway? _____%
9. ...get into or out of a car? _____%
10. ...walk across a parking lot to the mall? _____%
11. ...walk up or down a ramp? _____%
12. ...walk in a crowded mall where people rapidly walk past you? _____%
13. ...are bumped into by people as you walk through the mall? _____%
14. ...step onto or off of an escalator while you are holding onto a railing? _____%
15. ...step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
16. ...walk outside on icy sidewalks? _____%

*Powell LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. Journal of Gerontology Med Sci 1995; 50(1):M28-34.

Total ABC Score: _____

Scoring: _____ / 16 = _____% of self confidence
Total ABC Score

MEDICARE PATIENTS ONLY
100% - _____% Function = _____% Impairment

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

DIZZINESS HANDICAP INVENTORY – Initial Visit

Name: _____ **Date:** _____

SECTION I

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

SECTION II - Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1.	Does looking up increase your problem?	Yes[1]	No[2]	Sometimes[3]
E2.	Because of your problem, do you feel frustrated?	Yes[1]	No[2]	Sometimes[3]
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes[1]	No[2]	Sometimes[3]
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes[1]	No[2]	Sometimes[3]
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes[1]	No[2]	Sometimes[3]
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	Yes[1]	No[2]	Sometimes[3]
F7.	Because of your problem, do you have difficulty reading?	Yes[1]	No[2]	Sometimes[3]
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes[1]	No[2]	Sometimes[3]
E9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes[1]	No[2]	Sometimes[3]
E10.	Because of your problem, have you been embarrassed in front of others?	Yes[1]	No[2]	Sometimes[3]
P11.	Do quick movements of your head increase your problem?	Yes[1]	No[2]	Sometimes[3]
F12.	Because of your problem, do you avoid heights?	Yes[1]	No[2]	Sometimes[3]
P13.	Does turning over in bed increase your problem?	Yes[1]	No[2]	Sometimes[3]
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes[1]	No[2]	Sometimes[3]
E15.	Because of your problem, are you afraid people might think you are intoxicated?	Yes[1]	No[2]	Sometimes[3]
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes[1]	No[2]	Sometimes[3]
P17.	Does walking down a sidewalk increase your problem?	Yes[1]	No[2]	Sometimes[3]
E18.	Because of your problem, is it difficult for you to concentrate?	Yes[1]	No[2]	Sometimes[3]
F19.	Because of your problem, is it difficult for you walk around the house in the dark?	Yes[1]	No[2]	Sometimes[3]
E20.	Because of your problem, are you afraid to stay home alone?	Yes[1]	No[2]	Sometimes[3]
E21.	Because of your problem, do you feel handicapped?	Yes[1]	No[2]	Sometimes[3]

E22.	Has your problem placed stress on your relationships with members of your family or friends?	Yes[1]	No[2]	Sometimes[3]
E23.	Because of your problem, are you depressed?	Yes[1]	No[2]	Sometimes[3]
F24.	Does your problem interfere with your job or household responsibilities?	Yes[1]	No[2]	Sometimes[3]
P25.	Does bending over increase your problem?	Yes[1]	No[2]	Sometimes[3]

SECTION II - Part II

Instructions: Put a check in the box that best describes you:

- ☐ **Negligible symptoms (0)**
- ☐ **Bothersome symptoms (1)**
- ☐ **Performs usual work duties but symptoms interfere with outside activities (2)**
- ☐ **Symptoms disrupt performance of both usual work duties and outside activities (3)**
- ☐ **Currently on medical leave or had to change jobs because of symptoms (4)**
- ☐ **Unable to work for over one year or established permanent disability with compensation payments (5)**

Therapist Use Only

Comorbidities:

☐Cancer
☐Diabetes
☐Heart Condition
☐High Blood Pressure
☐Multiple Treatment Areas
☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
☐Obesity
☐Surgery for this Problem
☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

FYZICAL THERAPY ATTENDANCE POLICY

FYZICAL Dizziness and Wellness Center strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellation, especially at the last minute, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

If you are more than 20 minutes late for your appointment and failed to notify us, treatment may be cancelled and a fee assessed for that appointment.

A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE to avoid being charged a $25.00 missed appointment fee.

Failure to show up for an appointment without notifying us will result in a fee being charged for that appointment. Furthermore, 3 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.

At week's end, ALL PATIENTS, regardless of insurance/third party payor will be charged $25.00 CANCELLATION FEE for each late, late-cancelled and no-show appointment. The PATIENT is responsible for the fee, not the insurance.

No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.

All cancellations and no shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor

Repeated failure to comply with this attendance policy will result in your name being placed on a "schedule based on availability" List. This will require you to call for an open appt. on each day that you would like to receive therapy. We will do everything possible to accommodate you, as space permits.

We believe that this policy is necessary for the benefit of all our patients so that we may continue to provide high quality treatment and service to everyone. All of the staff at FYZICAL Dizziness and Wellness Center appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

_____ ___/___/___

Signature Date