CONCUSSION CARE KELOWNA

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SECTION A: PATIENT INFORMATION

Date: _____

Name: _____ Age: _____
(Last Name) *(First Name)*

Address: _____ Date of Birth: _____

_____ Height: _____ Weight: _____

Contact No.: _____

Name of Person Completing the Form (If not patient): _____

Relation to the patient: ◯ PARENT ◯ SPOUSE ◯ Other, please specify: _____

Employment Status: ◯ EMPLOYED ◯ UNEMPLOYED ◯ RETIRED

Check what applies to you: ◯ STUDENT ◯ PERSON WITH DISABILITIES

Occupation (if employed): _____

Please indicate your job responsibilities: _____

If Employed, Are You:

☐ FULL TIME

☐ PART TIME

☐ CASUAL

Do you work shift work? ☐ Yes ☐ No

If "YES", what are your shifts?

☐ MORNINGS ☐ EVENINGS

☐ AFTERNOONS ☐ NIGHTS

SECTION B: MEDICAL HISTORY

1. Are left or right-handed:
   ◯ Left ◯ Right

2. Do you have any difficulty with hearing?
   ◯ Yes ◯ No
   Comments: _____

3. Do you have hearing problems?
   ◯ Yes ◯ No
   If YES, when did your hearing problem present? ◯ Before injury ◯ After injury
   Approx. Date: _____
   Have you seen a specialist for this
   ◯ Yes ◯ No

4. Do you have any difficulty with vision?
   ◯ Yes ◯ No
   If YES, when did your vision problem present? ◯ Before injury ◯ After injury
   Approx. Date: _____

5. Do you have problems with eye strain/ double vision?

◯ Yes ◯ No

Comments:_____

When did your eye concerns present? _____

6. Have you seen an ophthalmologist or optometrist for this?

◯ Yes ◯ No

7. Have you been diagnosed with a cervical strain or whiplash injury?

◯ Yes ◯ No If YES, when: _____

8. Are you in pain from the injury?

◯ Yes ◯ No Comments: _____

9. Are you in chronic pain?

◯ Yes ◯ No Comments: _____

10. Have you ever been treated for depression?

◯ Yes ◯ No Comments: _____

11. What activities were you involved in prior to your injury? (e.g. hobbies, sports, volunteering, etc.)

_____

_____

12. Has your ability to participate in these activities changed since your accident?

◯ Yes ◯ No Comments: _____

SECTION C: BACKGROUND INFORMATION

1. Date of injury/illness (Month/Day/Year)

_____

2. Did you lose consciousness?

◯ YES ◯ NO

If YES, what is the approximate length of time you're unconscious? (Seconds/Minutes/Hours)

_____

3. Do you remember the accident and/or events immediately?

◯ YES ◯ NO

Comments:_____

4. Were you hospitalized?

◯ YES ◯ NO

If YES, which hospital? _____

Comments: _____

5. Have you had a CT or MRI?

◯ YES ◯ NO

If YES, which one? N/A

If YES, where was this done? _____

Comments: _____

6. What are the causes of your injury? **Check all that applies to you:**

- ☐ Motor Vehicle Accident
- ☐ Motor Vehicle Accident & Pedestrian
- ☐ Work Accident
- ☐ Bike Accident
- ☐ Assault
- ☐ Pedestrian Fall
- ☐ Hit by Falling Object
- ☐ Stroke
- ☐ Aneurysm
- ☐ Seizure
- ☐ Sports (What type of sports) _____
- ☐ Other Reasons _____

7. Have you had any problems with any of the conditions listed below prior to this head injury? **Check all that applies to you:**

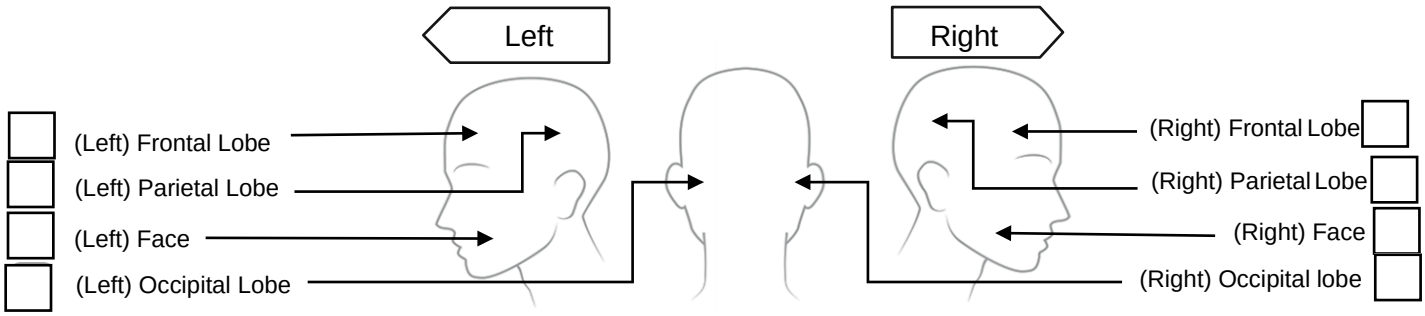
- ☐ attention deficit disorder (ADD)
- ☐ attention deficit hyperactivity disorder (ADHD)
- ☐ Headaches
- ☐ Anxiety
- ☐ Car or motion sickness
- ☐ Eye problems (such as a "lazy eye") as a child.

8. Prior to this injury, have you ever had a concussion or other neurological event?

◯ YES ◯ NO

Describe:

9. Please put a check (/) on this diagram where your head was hit:



10. Do you have a concussion history?

◯ YES ◯ NO ◯ NOT SURE

Previous number of concussions: (circle)

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 6+

11. Have you had previous baseline cognitive testing performed (ImPACT)?

◯ YES ◯ NO

If YES, where was this done? _____

12. Who is your family doctor (first and last names)? _____

13. Who are the other providers most involved in managing your concussion?

Name of Practitioner	Practitioner location / Phone Number
_____	_____
_____	_____
_____	_____
_____	_____

14. Who lives in your household?

15. Has your living situation changed since your injury?

◯ YES ◯ NO Comments: _____

SECTION D: THE EPWORTH SLEEPINESS SCALE

Please use this scale to rate the likelihood of you **DOZING** or **FALLING ASLEEP** in the following situations, in contrast to just feeling tired. This refers to our usual way of life in recent times.

Even if you have not done some of these things recently, try to estimate how they would have affected you.

How likely are you to doze or fall asleep when:	Never (0)	Slight Chance (1)	Moderate Chance (2)	High Chance (3)
Sitting and Reading	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯
Sitting inactive in public place (Theatre or Meetings)	◯	◯	◯	◯
As a passenger in a car for an hour without a break	◯	◯	◯	◯
Lying down to rest in the afternoon when circumstances permit	◯	◯	◯	◯
Sitting and talking to someone	◯	◯	◯	◯
Sitting quietly after a lunch without alcohol	◯	◯	◯	◯
In a car, while stopped for a few minutes in traffic	◯	◯	◯	◯

SECTION E: SLEEP INFORMATION	Workdays	Non-workdays
What time do you normally go to bed?		
Estimate how long it takes you to fall asleep:		
Estimate the number of times you wake up during the night:		
Estimate the average time it takes you to fall back to sleep:		
What time do you wake up in the morning?		
What time do you actually get up?		
Estimate the average number of hours of actual sleep (including light sleep):		
If you use an alarm, what time is it set for?		

SECTION F: SLEEP INFORMATION

1. Do you feel rested when you get up? ◯ Yes ◯ No
2. How many hours of sleep do you normally need to feel rested? _____
3. How much caffeine do you use per day? _____
4. How much nicotine do you use per day? _____
   If you've quit, when did you quit? _____
5. How much alcohol do you use per week? _____
6. Do you use any other recreational drugs? ◯ Yes ◯ No
   If yes, list _____
7. Do you have trouble with your sleep? ◯ Yes ◯ No
   If yes, for how many weeks/months/years? _____
8. Do you have trouble with daytime sleepiness? ◯ Yes ◯ No
   If yes, for how many weeks/months/years? _____
9. Do you have trouble with fatigue? ◯ Yes ◯ No
   If yes, for how many weeks/months/years? _____
10. Are you aware of anything that triggered your difficulty sleeping?
    _____

SECTION G: DIZZINESS HANDICAP INVENTORY

Do you have dizziness, spinning, or vertigo? ◯ Yes ◯ No
If YES, please complete the following Dizziness Handicap Inventory:

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

DIZZINESS HANDICAP INVENTORY	YES (4)	SOMETIMES (2)	NO (0)
Does looking up increase your problem?	◯	◯	◯
Because of your problem, do you have difficulty getting into or out of bed?	◯	◯	◯
Do quick movements of your head increase your problem?	◯	◯	◯
Does turning over in bed increase your problem?	◯	◯	◯
Does bending over increase your problem?	◯	◯	◯

THE RIVERMEAD POST-CONCUSSION SYMPTOMS QUESTIONNAIRE

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below.

As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom**, please shade the circle closest to your answer.**

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

	Not experienced at all (0)	**No more of a problem (1)**	**A mild problem (2)**	**A moderate problem (3)**	**A severe problem (4)**
Headaches	○	○	○	○	○
Feelings of Dizziness	○	○	○	○	○
Nausea and/or Vomiting	○	○	○	○	○
Noise Sensitivity, easily upset with loud noise	○	○	○	○	○
Sleep Disturbance	○	○	○	○	○
Fatigue, tiring more easily	○	○	○	○	○
Being irritable, easily angered	○	○	○	○	○
Feeling Depressed or Tearful	○	○	○	○	○
Feeling Frustrated or Impatient	○	○	○	○	○
Forgetfulness, poor memory	○	○	○	○	○
Poor Concentration	○	○	○	○	○
Taking Longer to Think	○	○	○	○	○
Blurred Vision	○	○	○	○	○
Light Sensitivity, easily upset by bright light	○	○	○	○	○
Double Vision	○	○	○	○	○
Restlessness	○	○	○	○	○

Are you experiencing any other difficulties?

1.	○	○	○	○	○
2.	○	○	○	○	○

ACTIVITY RATING SCALE

Please indicate (by /) if you are having difficulty now with the following activities compared to before your injury:

Home:	(✓)
1. Preparing meals	
2. Housecleaning	
3. Managing finances	
4. Listening to radio/watching TV	
5. Following conversations	
6. Talking on the phone	
7. Laundry	
8. Gardening/Yard work	
9. Parenting/Caring for family members	
10. Self care	
11. Entertaining	
12. Other:	

Work/School	(✓)
1. Following schedule	
2. Initiating tasks	
3. Reading complex material	
4. Remembering what needs to be done	
5. Completing work in a timely manner	
6. Working in presence of distractions	
7. Socializing in groups	
8. Making or keeping appointments	
9. Getting along with coworkers	
10. Maintaining stamina	
11.Composing written documents	
12. Working on a computer	
13. Other:	

Community:	(✓)
1. Driving	
2. Following directions/using a map	
3. Attending activities/functions with children	
4. Eating in restaurants	
5. Socializing in groups	
6. Grocery shopping	
7. Errands	
8. Using ATM/Banking	
9. Keeping appointments	
10.Automobile repairs and maintenance	
11. Using public transportation	
12. Other:	

Comments:

Therapy Goals:

What are your goals/hopes for our work together?

_____

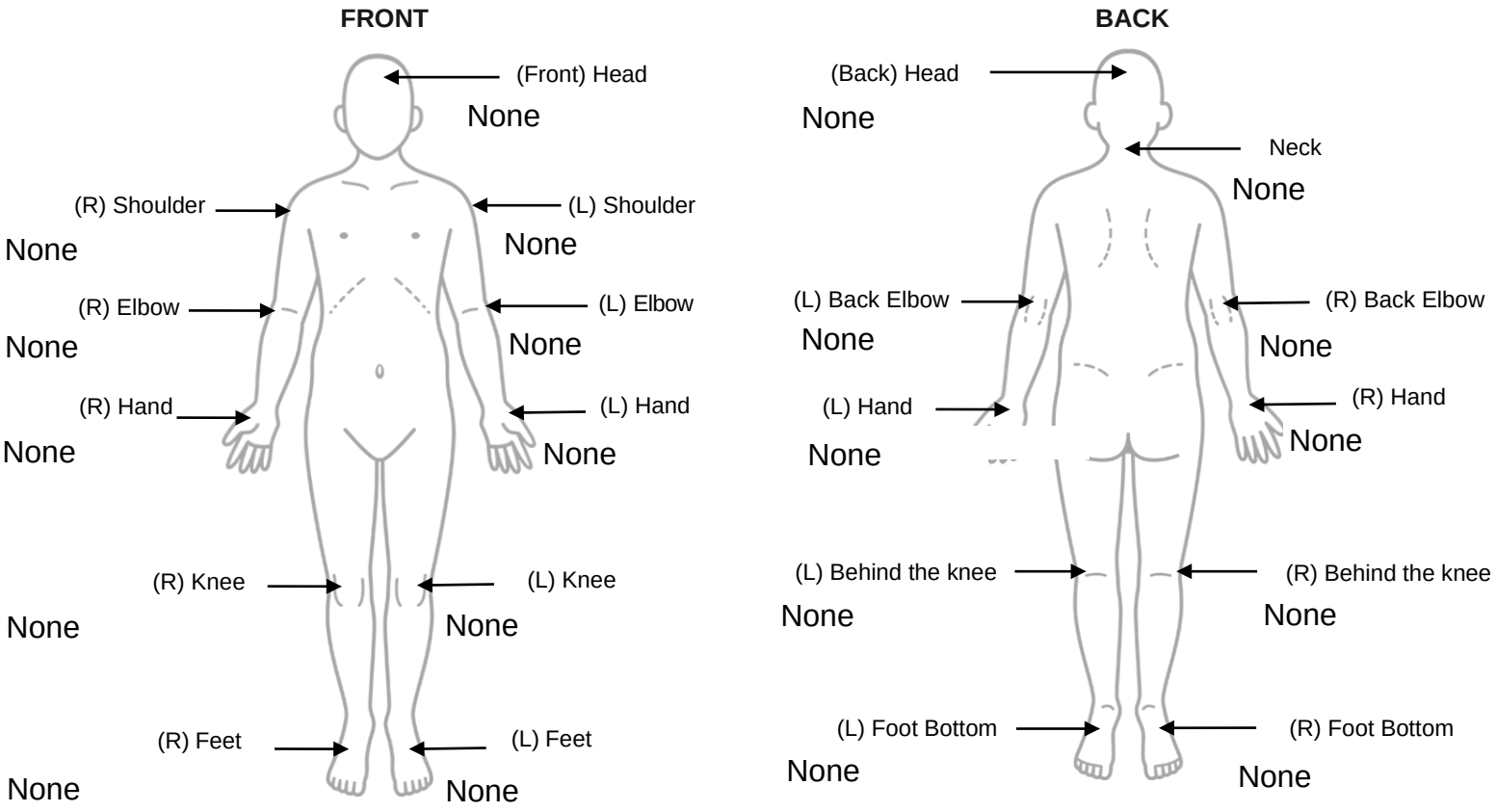
_____

_____

PAIN DIAGRAM AND RATING

Use the diagram below to indicate the symptoms you have experienced over the past 24 hours.
Be VERY precise when drawing the location of your pain. Use the key to indicate the type of symptoms.

Key: **Pins and Needles = 000000** **Stabbing = //////////** **Burning = xxxxxx** **Deep Ache = zzzzzz**



Please choose the **CURRENT** level of pain that you have experienced on the scale (Shade one below)

(No Pain) *(Worst imaginable pain)*

0 1 2 3 4 5 6 7 8 9 10

Please choose the **WORST** level of pain that you have experienced in the last 24 hours on the scale (Shade one below)

(No Pain) *(Worst imaginable pain)*

0 1 2 3 4 5 6 7 8 9 10

Please choose the **LEAST** level of pain that you have experienced in the last 24 hours on the scale (Shade one below)

(No Pain) *(Worst imaginable pain)*

0 1 2 3 4 5 6 7 8 9 10

ALLERGIES

Do you have allergies AND/OR are you allergic to any drugs?

◯ YES ◯ NO

If you answered "**YES**", please list your allergies AND/OR drug allergies:

MEDICATIONS

Your Pharmacy Name _____

Pharmacy Address _____

Are you taking any prescription medications or over the counter medications?

◯ YES ◯ NO

If **"YES",** please list drug name, dosage and when you take your medications. **Fill out the table below**.
(You can also attach a pharmacy printout of your medications.)

Medication Name:	Dosage:	Number of tablets and when you take it (ex: 1 tablet daily)

Select **YES** or **NO** if you prefer us to call your Pharmacy to request for your medication list.

◯ YES ◯ NO