Neuropsychological History and Concussion Form

Carolina Neuropsychological Service, Inc

Child's Name:___________________ Parents Name: ______________Date_________

Age_________ Date of Birth ______________________ Sex_________________

Grade:___________________ Name of School:___________________________

Hand child uses for writing or drawing:

Right____ Left: _____ Switches between them_________

Sports played: _____Football _____Soccer _____Lacrosse ____Hockey ____Baseball ______Cheerleading _____Basketball ____Softball ____Wrestling _____Other

Sports Level: ___________________________

List Current Medications: New? YES NO

___________________________________ Yes____ No____

___________________________________ Yes____ No____

___________________________________ Yes____ No____

___________________________________ Yes____ No____

Academics Yes No Explain

Ever repeated/skipped a grade Y N ________________________________

Ever diagnosed with a Learning Disability Y N ________________________________

Ever diagnosed with ADHD Y N ________________________________

Grades (Before Concussion)	Grades (After Concussion)
_______Above Average	______Above Average
_______ Average	______Average
_______Below Average	______Below Average

List your current courses:

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

List dates of all concussions and mechanism of injury (Sports, Car wreck, Fall, etc):

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Medical History

A) Birth/Development:

Uncomplicated pregnancy ____Pregnancy complications (If so, explain): ____________________

Vaginal Delivery____ C Section____ Breech or other _______

At term_____ Premature ______ Fetal Distress_______ NICU _________

Milestones (circle):				
	1) Walked alone:	Early	Average (9-18months)	Late
	2) Followed simple commands:	Early	Average (12-18months)	Late
	3) Used 1-2 word Sentences:	Early	Average (12-24months)	Late

B) Health History

Does your child have any of the following medical problems?	Yes	No	Explain
Prolonged Fever as an infant	Y	N	___________________________
Febrile Seizures in childhood	Y	N	__________________________
Headaches/Migraines	Y	N	__________________________
Seizures/Epilepsy	Y	N	__________________________
Vocal/Motor Tics	Y	N	__________________________
ADHD/ Attention/ Focus issues	Y	N	__________________________
Learning Disability/ Learning issues	Y	N	__________________________
Anxiety	Y	N	__________________________
Depression	Y	N	__________________________

C) **Family Medical History**

Has either parent or a grandparent or a sibling had any of the following?			Explain/Who ?
Headaches/Migraines	Y	N	__________________________
Seizures/Epilepsy	Y	N	__________________________
ADHD/ Attention/ Focus issues	Y	N	__________________________
Learning Disability/ Learning issues	Y	N	__________________________
Anxiety	Y	N	__________________________
Depression	Y	N	__________________________

D) Please list any other significant medical history not covered above:

Please rate the current level for each of these symptoms. "0" means none, while "6" is the most severe level. Rate yourself as you are feeling now. Circle the number.

Symptom	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Sleep more than usual	0	1	2	3	4	5	6
Numbness/tingling	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Feeling in a "fog"	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
Neck pain	0	1	2	3	4	5	6
Fatigue	0	1	2	3	4	5	6
Difficulty sleeping	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6

Has your child had any of the following symptoms since his/her concussion?

Symptom	Yes	No	Explain
Headache			
Nausea			
Vomiting			
Balance Problems			
Dizziness			
Fatigue			
Trouble falling asleep			
Sleeping more than usual			
Sleeping less than usual			
Drowsiness			
Sensitivity to light			
Sensitivity to noise			
Irritability			
Sadness			
Nervousness			
Feeling more emotional			
Numbness or tingling			
Feeling slowed down			
Feeling mentally foggy			
Difficulty concentrating			
Difficulty remembering			
Visual problems			
Total Symptom Score			

Comments: ____

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