THOMSON MEMORY CENTER

PATIENT NAME:
M.R. NUMBER:

PRE-VISIT QUESTIONNAIRE - Concussion

INSTRUCTIONS FOR COMPLETING

Please answer the following questions about your health and history. Although this form is lengthy, it is designed to be very thorough. Completing this information before your appointment will greatly assist the doctor to best use your assessment time with her /him by enabling a more detailed focus.

Name of Patient: _____ Date of Evaluation: _____

If form not completed by patient, name of person completing & relationship to patient:

_____ _____

NAME **RELATIONSHIP TO PATIENT**

_____

PHONE NUMBER

PRESENTING PROBLEM

Please briefly describe how your head injury occurred:

Date of Occurrence: _____

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Please check each symptom that occurred following the head injury and if it is still present.
If the symptom is no longer present, please list how long it occurred following the injury (e.g., 1 hour, 3 days, etc.)

Following Injury	Now		If following injury, for how long did the symptom last?
○	○	Loss of consciousness	_____
○	○	Headache or head pressure	_____
○	○	Confusion or mental fogginess	_____
○	○	Forgetfulness of events following injury	_____
○	○	Forgetfulness of events prior to the injury	_____
○	○	Dizziness or seeing stars	_____
○	○	Nausea or vomiting	_____
○	○	Ringing in the ears	_____
○	○	Slurred speech	_____
○	○	Fatigue	_____
○	○	Sadness	_____
○	○	Irritability	_____
○	○	Concentration problems	_____
○	○	Memory problems	_____
○	○	Sensitivity to light	_____
○	○	Sensitivity to noise	_____

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◯	◯	Sleep problems	_____
◯	◯	Changes in taste or smell	_____
◯	◯	Unsteady balance	_____
◯	◯	Vision changes	_____
◯	◯	Seizure(s)	_____

Are your symptoms improving over time? ◯ Yes ◯ No

What symptoms are stable (not getting worse, but not getting better)? _____

_____

What symptoms are getting worse? _____

_____

Have your daily activities changed and in what way? _____

_____

Did you go to the emergency department following the injury? ◯ Yes ◯ No

Did you have a CT or MRI of your brain? ◯ Yes ◯ No

Have you had previous head injuries? ◯ Yes ◯ No

If yes, how many? _____

If yes, when? _____