Date: _____

Baseline Concussion/Post-concussion

Registration and Background Information

Name: _____ DOB: _____/_____/_____ Age: _____ Gender: M F

Parent/Guardian: _____ Contact #: _____

Sport: _____ School/Team: _____

Contact email: _____

Years of Education Completed: _____

Dominant Hand: R L neither

How many concussions have you had in the past? _____

When was the most recent concussion? _____

How long was your recovery from your most recent concussion? _____

Have you ever been hospitalized or had medical imaging done for a head injury?	Y	N	Decline
Have you ever been diagnosed with headaches or migraines?	Y	N	Decline
Do you have a learning disability, dyslexia, ADD/ADHD?	Y	N	Decline
Have you ever been diagnosed with depression, anxiety, or other psychiatric disorders?	Y	N	Decline
Has anyone in your family ever been diagnosed with these problems?	Y	N	Decline
Are you on any medications? If so, please list:	Y	N	Decline