Baseline Worksheet

I. Demographic and Background Information

School / Organization: Thompson Junior High School/ CUSD 308

Date of Birth: _________ month ______ date _______year

First Name: ______________________ Last Name: _________________________

Height: _____ft _____in Weight: _______ Gender: _____ male _____ female

Handedness: _____ right _____ left _____ ambidextrous (both right and left)

Home Address: Street: ____

City: _______________________________________ Zipcode: _____________

Parent Email address: ____

Native Country / Region: ______________________________

Native Language: ____________________________________

Second Language: __________________________ (only if fluent in speaking and writing)

Years of education completed excluding kindergarten (e.g., 8th grade is 7 years): ________

Check any of the following that apply:

_____ Received speech therapy

_____ Attended special education classes

_____ Repeated one or more years of school

_____ Diagnosed attention deficit disorder or hyperactivity

_____ Diagnosed learning disability

What type of student are you?

_____ Below Average(mostly D&C) ______Average(Mostly C&B) ______Above Average(A&B)

Current Sport: ____

Current position / event / class: ___________________________

Current level of participation: Junior High

Years of experience at this level(Junior High): _______ (0 - 3)

Please list your 5 most recent concussions: __________ month __________ year
__________ month __________ year
__________ month __________ year
__________ month __________ year
__________ month __________ year

Concussion History

_____ Number of times diagnosed with a concussion (excluding current injury)
_____ Total number of concussions
_____ Total number of concussions that resulted in confusion
_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately after injury
_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately before injury
_____ Total number a games that were missed as a direct result of all concussions combine

Indicate if you have had any of the following:

_____ yes _____ no Treatment for headaches by physician
_____ yes _____ no Treatment for migraine headaches by physician
_____ yes _____ no Treatment for epilepsy / seizures
_____ yes _____ no Treatment for brain surgery
_____ yes _____ no Treatment for meningitis
_____ yes _____ no Treatment for substance abuse / alcohol abuse
_____ yes _____ no Treatment for psychiatric condition (depression, anxiety)

Have you been diagnosed with any of the following?

_____ yes _____ no ADD/ ADHD
_____ yes _____ no Dyslexia
_____ yes _____ no Autism

Date of your last concussion: __________ month _____ date _____ year

Number of hours slept last night: _____ (approximate if uncertain)

Please list any **PRESCRIPTION** medication (s) you are currently taking:

____

____

____