Physical Therapy &
Vestibular Rehabilitation

Adult Concussion Medical History Form

Patient Name: _____ Date of Birth: _____

Reporter: ___Patient ___Spouse ___Other: _____

Height: ____Ft____in Weight: _____lb Age: _____

In order for us to help you recover from your brain injury it is important to know as much as we can about how you were injured and what problems you've had since your injury.

1. What is the date of your most recent concussion?_____
2. Briefly describe the event that caused the concussion._____

   _____
3. Was this work related? Yes No If yes, is there litigation? _____
4. Work status: full time____ part time____
5. Did you miss work due to your concussion? _____
6. Did you lose consciousness (get knocked out) at the time of your concussion? Yes No
7. Have you lost your memory of events which occurred **before** your concussion? Yes No
8. Have you lost your memory of events which occurred **after** your concussion? Yes No
9. Did you have any neck pain following your injury? Yes No
10. How many concussions have you had in the past? 0 1 2 3 4 5 6 7 8 9 10 >10

Past Medical History: *(check all that apply)*

___Attention deficit hyperactivity disorder (ADHD)
___Seizures
___Frequent headaches
___Dyslexia
___Motion sickness (ex. Car or plane rides)
___A learning disability
___Hypertension
___Bowel or bladder difficulties
___Circulatory Disorders
___Depression
___Anxiety
___Diabetes
___Dizziness
___Noise in ears
___Double vision
___Currently Pregnant
___Migraines/family history of migraine
___Other:
___Heart disease
___Lung disease
___Obesity
___Osteoporosis/osteopenia
___Smoker
___Take Steroids
___Cancer

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Eye health/surgeries: strabismus amblyopia glaucoma family history of eye issues

Do you or did you have sensitivity to: light noise busy environments

Diagnostic tests: MRI Computerized Posturography Hearing IMPACT/Cognitive testing

Previous surgeries/injuries:_____

_____

Medications (prescription). Please include name, dose, and frequency:

Over-the-counter medications: Advil, Motrin, Alleve, Tylenol

Allergies to medications, foods, or contrast agents (include reaction):

Goals for therapy:_____

Rate the following on a scale of 0 to 10 (0 if no symptoms, 10 is enough to severely interfere with function):

Headache: at rest: _____ with activity: _____

Dizziness: at rest: _____ with activity: _____

Nausea: at rest: _____ with activity: _____

Cervical Pain: at rest: _____ with activity: _____

Disequilibrium: at rest: _____ with activity: _____