Pediatric Neurology

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CONCUSSION EVALUATION QUESTIONNAIRE

Please complete this questionnaire. It will be an important part of your child's medical record.

Patient Name: _____ Today's Date: _____

DOB: _____ Age: _____

Dominant hand: ☐ Right ☐ Left ☐ Both ☐ Don't know

Concussion history:

Date of Concussion:
How was the concussion caused?
☐ Football ☐ Hockey ☐ Soccer ☐ Lacrosse ☐ Other activity:

What happened? _____

_____

_____

Was there a helmet in place: (YES ☐ or NO ☐) Was there a mouth guard in place: (YES ☐ or NO ☐):

When the injury occurred, which of the following immediately happened ? Check all that apply

☐ Became dazed or confused ☐ Vision changes ☐ Dizziness ☐ Headache ☐ Vomiting

☐ Loss of consciousness If yes, estimated duration (min.): _____

☐ Loss of memory after concussion If yes, estimated duration (min.): _____

☐ Loss of memory before concussion: If yes, estimated duration (min.): _____

Other _____

Did you take your child to the ER? (YES ☐ or NO ☐) To an outpatient doctor's office/clinic? (YES ☐ or NO ☐)

Was a CT scan done? (YES ☐ or NO ☐) An MRI? (YES ☐ or NO ☐)

Was your child admitted to the hospital? (YES ☐ or NO ☐) If yes, for how long? (YES ☐ or NO ☐)

Please list any medications given due to the concussion:

_____

Did your child stay at home and rest after the injury?

☐ Yes ☐ No

If yes, how many days? _____

Is your child back in school ☐ Yes ☐ No If No, how many school days missed: _____

Any concussions in the past? _____

If yes, please provide dates: _____

If any, # with loss of consciousness: _____

Other description of past concussion: _____

Any past history of:

Headaches: (Y ☐ / N ☐): Learning Disability: (Y ☐ / N ☐): ADD: (Y ☐ / N ☐):

Anxiety: (Y ☐ / N ☐): Depression: (Y ☐ / N ☐): Sleep Disorder: (Y ☐ / N ☐):

Other Psychiatric: _____

Overall, how does your child feel now compared to before the concussion ?
☐ No Different ☐ Very Different ☐ Not sure

Does physical activity or exercise worsen any symptoms ? ☐ Yes ☐ No

Does mental activity (attention, concentration) worsen any symptoms ? ☐ Yes ☐ No

Do you currently have headaches? ☐ YES ☐ NO

If yes, please answer the HEADACHE HISTORY questions below:

Concussion Symptoms

Please rate the presence of the following symptoms of concussion. Rate each symptom separately for during the game, that night, the next today, and today, and rank them compared to how your child usually feels.

Rate the symptoms on a scale of **0 to 6** using this scale:

None: 0 Mild: 1 - 2 Moderate: 3-4 Severe: 5-6

	During game or injury	That Night	Next Day	Today
Dizziness				
Headache				
Nausea				
Vomiting				
Balance Problems				
Insomnia				
Sleeping more than usual				
Sleeping less than usual				
Drowsiness				
Low Energy/Fatigue				
Sensitivity to light				
Sensitivity to sound				
More Emotional than usual				
Irritability				
Sadness				
Nervous/Anxious				
Numbness or tingling				
Feeling slowed down				
Feeling "in a fog"				
Difficulty concentrating				
Feeling "pressure" in head				
Difficulty remembering				
Visual problems (blurred, double)				
Neck Pain				
Confusion				
Other:				

HEADACHE HISTORY (Please circle or check)

These questions should be completed by the patient. If a parent/guardian is filling the form, make sure the responses are the patient's.

Do you have more than one headache type?

☐ No
☐ Yes *(If yes, please answer the following questions for your first headache type, then describe your second headache on last page)*

1. **Are you ever headache free**:
   ☐ Yes ☐ No

   ☐ Vacation ☐ Weekends ☐ Weekdays ☐ Random Other: _____

2. **Onset of First Headache**
   Headaches started when I was _____years old.

3. **Precipitating Events**
   What provoked your first headache?
   ☐ None ☐ Injury ☐ Menarche (first period) Other: _____

4. **Frequency:**
   How often does the headache occur?

   ☐ less than 1/month ☐ 1 to 3/month ☐ 1 /week ☐ 2 to 3/week ☐ more than 3/week

   ☐ Daily ☐ Continuous Other: _____

   How many months has it been this frequent? _____
   When are they most frequent:

   ☐ Weekends ☐ Weekdays ☐ Vacation ☐ Morning ☐ Afternoon ☐ Evening ☐ Varies

   Are they increasing in frequency: ☐ Yes ☐ No

5. **Durations:**
   How long do they last?

   Lasts _____ mins _____ hours _____ days (**with** medication)

   Lasts _____ mins _____ hours _____ days (**without** medication)

6. **Severity:** How bad is the pain? On a scale of 0 to 10, what is the severity of your headache?

   (0 = no pain; 5 = moderate pain; 10 = worst possible pain)

   ☐ Mild ☐ Moderate ☐ Severe Mildest: _____ Worst: _____

7. Location:

☐ Front of head ☐ Side of head ☐ Back of head ☐ Around eyes ☐ Behind eyes ☐ All over

8. Sideness:

Does your headache occur on:

☐ One side of your head ☐ Both sides ☐ Sometimes on one side and sometimes on both sides

9. Character:

What does the pain of the headache feel like?

☐ Throbbing ☐ Squeezing ☐ Stabbing ☐ Pinching ☐ Pressure ☐ Burning ☐ Sharp ☐ Dull

Other: _____

10. Activity that worsens headache:

Does the headache change activity level (i.e., stop playing or doing normal activities)?	Yes ☐	No ☐	N/A ☐
Does cognitive activity or playing make the headache worse?	Yes ☐	No ☐	N/A ☐
Does bending over make it worse?	Yes ☐	No ☐	N/A ☐
Does standing up make it worse?	Yes ☐	No ☐	N/A ☐
Does straining or coughing make it worse?	Yes ☐	No ☐	N/A ☐
Does resting or sleeping make your headache get better or go away?	Yes ☐	No ☐	N/A ☐

11. What symptoms occur with the headache? *(Please review carefully)*

☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to sound ☐ Sensitivity to smells ☐ Lightheadedness

☐ Spinning sensation ☐ Tearing eyes ☐ Runny nose ☐ Decrease appetite ☐ Stomach pain ☐ Fatigue

☐ Ringing in the ear ☐ Changes in vision ☐ Confusion ☐ Difficulty with - thinking /walking /using arms/talking

Other: _____

12. Do you have these visual symptoms before your headache begins? *(Questions for Visual Aura)*

☐ Zigzag lines ☐ Flashing lights ☐ Loss of vision on one side ☐ Blurry vision

☐ Tunnel vision ☐ Double vision ☐ Total blindness Other changes in vision: _____

How long do these symptoms last? _____ minutes _____ hours

How soon after your headache starts do these symptoms begin? _____ minutes

13. Premonitory Symptoms
Do you experience any of the following BEFORE the headache starts?

☐ Tired ☐ Irritable ☐ Hyperactive ☐ Depressed ☐ Feeling "Not right" ☐ Food cravings

☐ Extremely talkative ☐ Difficulty with speech ☐ Sunken eyes ☐ Flushed face ☐ Diarrhea ☐ Constipation

14. Provoking Factors: (things that bring on a headache)

Food/beverage: ☐ Fasting ☐ Chocolate ☐ Caffeine ☐ Cold cuts Other: _____

Physical exertion: ☐ Coughing ☐ Talking ☐ Chewing ☐ Exercise

Hormonal: ☐ Menses: ☐ Before ☐ During ☐ After

Stress: ☐ School ☐ Home Other _____

Environmental: ☐ Allergies ☐ Weather changes ☐ Altitude ☐ Sunlight ☐ Smells ☐ Light ☐ Noises

Sleep: ☐ Lack of sleep ☐ Too much sleep ☐ Change in wake/sleep

Other triggers: _____

15. Relieving Factors:

☐ Lying down ☐ Dark quiet room ☐ Hot compress ☐ Cold compress ☐ Keeping active/pacing

☐ Standing ☐ Massage Other: _____

16. Do you experience any of the following during your headache
☐ Numbness/Tingling- Right
☐ Numbness/Tingling- Left
☐ Numbness/Tingling- Both
☐ Unable To Speak
☐ Decreased Consciousness
☐ Unsteadiness/Severe
☐ Dizziness
☐ Double Vision
☐ One-Sided Weakness

Previous treatments: (please give name of provider, date, type of treatment and if it helped)

	Name of provider, date, type of treatment
Primary care provider	
Neurologist	
Otolaryngologist (ENT)	
Dentist/dental	
Ophthalmologist	
Psychiatrist/psychologist	
Biofeedback/relaxation	
Physical therapy	
Other	

Previous Test: (Please give date and results)

Test	Date	Result (normal or abnormal)
Brain MRI		
MRA/MRV		
Cervical MRI		
Head CT		
EEG		
Lumbar Puncture		
EMG		
Sleep Study		

Previous Preventive Headache Medication: (please check any medication that you have taken everyday for your headache)

- ☐ Elavil (Amitriptyline)
- ☐ Pamelor (Nortriptyline)
- ☐ Topamax (Topiramate)
- ☐ Inderal (Propranolol)
- ☐ Depakote (Valproic Acid)
- ☐ Other: _____

Previous Abortive Headache Medication (please check any medication that you have taken for your headache)

- ☐ Advil (ibuprofen)
- ☐ Aspirin
- ☐ Aleve
- ☐ Tylenol
- ☐ Imitrex
- ☐ Other: _____

Vitamins, other supplements or herbal medications for headaches:

☐ Coenzyme Q ☐ Magnesium ☐ Vitamin B2 (Riboflavin) ☐ Vitamin D ☐ Melatonin ☐ Other:_____

Current Medications:

Medication	Dose	How Often

Habits:

Eating:

Do you skip any meals? ☐ Yes ☐ No
Which meals do you skip? ☐ Breakfast ☐ Lunch ☐ Dinner

Drinking:

How much total fluids do you drink a day? _____ # of total ounces or _____ # of glasses

Do you carry a water bottle? ☐ Yes ☐ No

Do you drink caffeine-containing beverages? ☐ Yes ☐ No
How many days per week? _____

Exercise:
Do you exercise? ☐ No ☐ Yes

How long do you usually exercise per day? _____ minutes / hours (please circle)

Sleeping:
I get _____ hours of sleep per night.

Check all that apply:

☐ I have difficulty falling asleep
☐ I have trouble staying asleep
☐ I wake up during the night or early morning for no apparent reason
☐ My headache awakes me
☐ I wake up with a headache
☐ I snore

Weekdays: Bedtime _____ Wake up time _____
Weekends: Bedtime _____ Wake up time _____

PAST MEDICAL HISTORY:

What was the patient's birth weight: _____lbs_____ounces

Were there any problems with the pregnancy, labor or delivery? ☐ Yes ☐ No

If yes, please explain: _____

Was your development normal? ☐ Yes ☐ No

If no, please explain: _____

Have you ever been diagnosed with any medical or psychiatric problems?

☐ Brain infections ☐ Seizures ☐ Strokes ☐ ADD/ADHD ☐ Asthma ☐ Seasonal allergies
☐ Recurrent sinusitis ☐ Anxiety ☐ Depression ☐ Hospitalizations ☐ Surgeries
Other: _____

Have you had any of the following problems?

☐ Motion/Car sickness ☐ Difficulty sleeping ☐ Sleep walking ☐ Sleep talking ☐ Night terrors
☐ Snoring ☐ Unexplained fevers ☐ Repeated episodes of stomach pain or vomiting (without headache)
☐ GE Reflux ☐ Fainting spells ☐ Feeling anxious ☐ Feeling depressed ☐ Shyness
☐ Feelings of low self-esteem ☐ Worrying a lot
☐ Difficulty at school with: ☐ Bullies ☐ Homework ☐ Grades

For female patients

Menstrual History:

At what age did your menstrual periods start? _____

Menses occur monthly: Yes ☐ No ☐

Last menstrual period: _____

Are your headaches worse with your periods? Yes ☐ No ☐ Not sure ☐

If you haven't had a period OR they just started, do you have monthly headaches? Yes ☐ No ☐ Not sure ☐

Are you on birth control? _____

Social History

Who lives in the same house with the patient?

Name	Age	Relationship to Patient

Are the parent(s) ☐ Single
☐ Married ☐ Separated ☐ Divorced ☐ Remarried

What grade are you currently in at school? _____

School performance (i.e., grades) _____

Have your headaches caused your academic performance to change? Yes ☐ No ☐

School type:
☐Public ☐ Private ☐ Home schooled ☐ College

Difficulty at school with: ☐ Bullies ☐ Homework ☐ Grades

Any unusual stresses at home or at school? ☐ Yes ☐ No

Any drug use/abuse? Yes ☐ No ☐ Alcohol use/abuse? Yes ☐ No ☐

Tobacco use/abuse? Yes ☐ No ☐ Sexually active? Yes ☐ No ☐

Have you ever been abused? Yes ☐ No ☐

Family History

Please check the box if your family members have had ANY of the following and list the person's relationship to the patient next to the problem:

☐ Migraine headaches
☐ Headaches (any type)
☐ Seizures
☐ Mental retardation
☐ Developmental delay
☐ Speech delay
☐ Attention Deficit
☐ Learning Disabilities
☐ Autism
☐ Brain Tumors
☐ Hypertension
☐ Heart Disease
☐ Strokes
☐ Psychiatric Disorder
☐ Addiction Disorder
☐ Genetic disorder
☐ Other diseases:

Review of Systems: ☐ Eyes ☐ Ears ☐ Nose ☐ Throat ☐ Heart problems ☐ Chest pains
☐ Trouble breathing ☐ Shortness of breath ☐ Wheezing ☐ Stomach ☐ Pains ☐ Nausea
☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Urination ☐ Muscle aches ☐ Arm pain
☐ Leg pain ☐ Joint pain ☐ Back pain ☐ Bleeding problems ☐ Fever ☐ Colds
☐ Coughs ☐ Weight changes ☐ Rashes/skin changes

IF YOU HAVE MORE THAN ONE HEADACHE TYPE PLEASE USE THIS SPACE FOR YOUR SECOND HEADACHE:
Describe your second headache type:

Race and Ethnicity Information

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

Primary Language

- ☐ Albanian
- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Bengali
- ☐ Bosnian
- ☐ Cantonese (Chinese)
- ☐ Creole
- ☐ Croatian
- ☐ ECH
- ☐ Danish
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hebrew
- ☐ Hindi
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Latin
- ☐ Malay
- ☐ Mandarin (Chinese)
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Romanian
- ☐ Russia
- ☐ Serbian
- ☐ Slovak
- ☐ Spanish
- ☐ Swahili
- ☐ Swedish
- ☐ Tagalog
- ☐ Thai
- ☐ Turkish
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yiddish
- ☐ Yugoslavian
- ☐ Other
- ☐ Declined
- ☐ Unknown

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Island
- ☐ White
- ☐ Other Combination Not Described
- ☐ Declined

Ethnicity

- ☐ Hispanic or Latino or Spanish Origin
- ☐ Not Hispanic or Latino or Spanish Origin
- ☐ Declined

Pharmacy Information

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

☐ New

Date:

Patient Name:

NYH #:

PRIMARY
Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)
Pharmacy Name:

Address:

Phone Number:

Fax Number:
