Robert C. Cantu Concussion Center
Emerson Hospital

NEUROLOGICAL / CONCUSSION HISTORY

Chief Complaint: _____

Date of Injury: _____ How was the injury sustained? _____

Referring MD: _____

Previous Neurological Exams: _____

History of Present Illness: _____

Have you had any falls within the past 6 months? Yes ◯ No ◯

If yes, when? _____

Have you ever been diagnosed with a concussion? Yes ◯ No ◯

If yes, how many concussions have you had? # _____

Have you ever lost consciousness as a result of a head injury? Yes ◯ No ◯

Have you ever been hospitalized as a result of a head injury? Yes ◯ No ◯

If yes, where? _____

Details: _____

Have you ever had any imaging studies done of your brain? (CT, MRI, DTI?) Yes ◯ No ◯

If yes, what type? _____

Date of most recent imaging studies: _____

Details: _____

Are you experiencing any of the following? Please ✓ all that apply.

General Review of Systems:

☐ Fever	☐ Neck swelling	☐ Skeletal deformities	☐ Blind spots
☐ Night sweats	☐ Limited neck movement	☐ Muscle/joint pain	☐ Hearing impairment
☐ Poor appetite	☐ Wheezing	☐ Back pain	☐ Vision impairment
☐ Change in weight	☐ Abdominal pain	☐ Difficulty walking	☐ Flashing lights
☐ Disorientation	☐ Bowel/bladder problems	☐ Imbalance	☐ Migraine headaches
☐ Runny nose	☐ Constipation	☐ Face weakness	☐ Trouble swallowing
☐ Sore throat	☐ Diarrhea	☐ Moles	☐ Trouble talking
☐ Dental problems	☐ Reflux/heartburn	☐ Itching	☐ Other:
☐ Chest pain	☐ Pain with urination	☐ Growth problems	
☐ Shortness of breath	☐ Blood in urine	☐ Temperature irregulation	
☐ Cough	☐ Frequent/urgent urination	☐ Thyroid problems	
☐ Heart murmur	☐ Unusual urine odor	☐ Abnormal bleeding	
☐ Palpitations/Irregular heartbeat	☐ Menstrual irregularities	☐ Lymph node swelling	

GENERAL HISTORY

Height: _____ Weight: _____

List any medications you are currently taking: _____

_____

_____

Do you have any allergies? Yes ◯ No ◯ Do you have a Latex allergy? Yes ◯ No ◯

If yes, please list: _____

Do you presently or have you in the past used any drugs (i.e. marijuana, cocaine, pills, etc.) Yes ◯ No ◯

Do you smoke? Yes ◯ No ◯ If yes, how much? _____ Age started? _____

Do you drink alcohol? Never ◯ Rarely ◯ Occasionally ◯ Frequently ◯

How many cups of caffeinated beverages per day? # _____

Patient lives with: _____

School (circle one): Grade ◯ Middle ◯ High School ◯ College ◯ Trade School ◯ Other: _____

Are you employed? Yes ◯ No ◯ If yes, what type of job? _____

Sports: _____ Leisure/Hobbies: _____

Have you/your child had any past hospitalizations? Yes ◯ No ◯

If yes, describe: _____

List any major operations: _____

Are you being hurt or made to feel afraid? Yes ◯ No ◯

Are you presently or potentially involved in a legal case? Yes ◯ No ◯

If yes, who is your attorney? _____

Have you ever been diagnosed with any of the following? Please ✓ all that apply.

☐ ADHD/ADD	☐ Digestive Problems	☐ Liver Disease or Hepatitis	☐ Substance Use Disorder
☐ Alcoholism	☐ Dyslexia	☐ Migraine Headaches	☐ Thyroid Disease
☐ Anxiety/Nervousness	☐ Eating Disorder	☐ Osteoporosis	☐ Tick Bites
☐ Asthma/Lung Problems	☐ Gallstones	☐ Panic Attacks	☐ Tremors
☐ Bleeding/Bruising	☐ Glaucoma	☐ Personality Change	☐ Ulcers
☐ Blood Clots	☐ Heart Problems	☐ Seizures	☐ Other Psychiatric Disorder
☐ Blood Disorder/Anemia	☐ High Blood Pressure	☐ Sexually Transmitted Infections	☐ Other Learning Disability
☐ Breast Problems	☐ High Cholesterol	☐ Significant Weight Gain	
☐ Cancer	☐ HIV/AIDS	☐ Skin Problems	
☐ Depression	☐ Joint Pain/Arthritis	☐ Sleep Disorders	
☐ Diabetes	☐ Kidney Disease	☐ Stroke	

FAMILY HISTORY

Please list ages and health status of all immediate family members:

Mother: _____

Father: _____

Siblings: _____

Children: _____

Please ✓ any health conditions that your blood-related family members currently have or have had in the past, and list the family member:

Condition	Family Member	Condition	Family Member
☐ ADHD/ADD		☐ High Blood Pressure	
☐ Anxiety		☐ Kidney Disease	
☐ Arthritis		☐ Migraine Headaches	
☐ Bleeding Disorder		☐ Multiple Sclerosis	
☐ Brain Tumor		☐ Nervous / Muscle Disorder	
☐ Cancer		☐ Panic Attacks	
☐ Dementia / Alzheimer's		☐ Parkinson's Disease	
☐ Depression		☐ Seizure Disorder	
☐ Diabetes		☐ Thyroid Disease	
☐ Dyslexia		☐ Tremor	
☐ Epilepsy		☐ Other:	
☐ Headache		☐ Other Learning Disability	
☐ Heart Disease		☐ Other Psychiatric Disorder	

_____ _____ _____

Signature of Patient or Patient's Legal Representative | Date | Time

_____ _____

Print Name Legal Representative (if applicable) | Relation to Patient