Dr. Robert C. Cantu Concussion Center

Emerson Hospital

310 Baker Ave. Concord, MA 01742 Phone: (978) 287-8250 Fax: (978) 287-8202

PATIENTS 21 YEARS OLD AND YOUNGER

NEUROLOGICAL / CONCUSSION HISTORY

Chief Complaint:____

Date of Injury: __________________ How was the Injury sustained: _____________________________________

Referring MD: ____

Previous Neurological Exams: ____

History of Present Illness: ____

Check if you have or have had any of the following:

Any falls in the past 6 months? If so, when: ____

Have you ever been diagnosed with a concussion? Yes No

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
Where: ____
Details: ____

Have you ever had any imaging studies done of your brain? (CT, MRI, DTI?) Yes No
Type: ____
Details: ____
Date of Most Recent Imaging Studies: ____________________________

Are you experiencing any of the following?
General Review of Systems:

	Fever		Neck Swelling		Skeletal deformities		Blind Spots
	Night Sweats		Limitation of 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 Problem		Reflux / Heartburn		Itching		
	Chest Pain		Pain with urination		Growth problem		Other:
	Shortness of Breath		Blood in urine		Temperature irregulation		
	Cough		Urinary frequency / urgency		Thyroid problem		
	Heart murmur		Unusual urine odor		Abnormal Bleeding		
	Palpitations / Irregular Heartbeat		Menstrual Irregularities		Lymph node swelling		

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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 Grade: _________

Do you work?: Yes No 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 check any that Apply:

	Anorexia/Bulimia		Heart Problems		Significant weight gain		Drug Abuse
	Bleeding/Bruising		High Blood Pressure		Skin Problems		Dyslexia
	Blood Clots		HIV/AIDS		Stroke		Other Psychiatric Disorders
	Blood Disorder/Anemia		Joint pain/arthritis		Thyroid Disease		Panic Attacks
	Breast Problems		Kidney Disease		Tick Bites		Personality Change
	Cancer		Liver Disease or Hepatitis		Ulcers		Seizure Disorder
	Diabetes		Lung Problems (Asthma)				Sleep Disorders
	Elevated Cholesterol		Migraine Headaches		ADD/ADHD		Tremor
	Gallstones		Osteoporosis		Alcoholism		Other Learning Disabilities:
	GI Problems (GERD, reflux, heartburn)		Seizures		Anxiety/Nervousness		
	Glaucoma		Sexually Transmitted Infection		Depression		

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FAMILY HISTORY

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

Mother: ____________________

Father: ____________________

Siblings: ____________________

Children: ____________________

Please check all that apply and list the family member:

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

If the patient is 10 years or older, please sign below and the questionnaire is complete. For patients 9 year old and younger, please fill out the last page.

____________________ ____________________ ____________________

Date Time Signature of Patient or Patient's Legal Representative

____________________ ____________________

Print Name of Patient's Legal Representative (if applicable) Relation to Patient

<u>If the patient is 9 years old or younger, please continue to the following page</u>

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PRENATAL HISTORY

Please circle any of the following that apply

During the pregnancy did mother have: Illness Fever Rash High blood pressure Physical Trauma Injury
During the pregnancy did mother take medication: Yes No If yes, name: ___________________________
Were fetal movements normal beginning with the fifth month of pregnancy?: Yes No
Did mother receive regular obstetrical care during pregnancy?: Yes No
How many pregnancies did mother have prior to this child?: ______________
Where there any prior abortions, miscarriages?: Yes No

NEONATAL (NEWBORN) HISTORY

How long was the pregnancy? ____________________ How long was the labor? _______________
Was delivery: Spontaneous Induced Child's Birth weight: _____________
If any, what medications were given during labor and delivery: ______________________________
Type of delivery: Vaginal Cesarean section
Did the child breathe and cry immediately following the delivery? ___________
Following a delivery and within the first month of life, did the child have any medical problems? ___________
If yes, what type ____
How many days after delivery was the child sent home? ____________________

DEVELOPMENTAL HISTORY

When did your child:
Smile for the first time _________________
Roll over front to back _________________
Hold his/her head up __________________
Roll from back to front _________________
Sit alone _____________________________
Pull to stand __________________________
Coo/babble ___________________________
Say recognizable words ________________
Speak in complete sentences ___________
Tell a story ___________________________

Crawl _______________________________
Walk without assistance ________________
Walk upstairs _________________________
Run _________________________________
Ride a tricycle ________________________
First dress herself/himself ______________
First tie shoelaces _____________________
Toilet trained _________________________
Learn body parts ______________________
Learn colors __________________________
Learn alphabet ________________________

School progress:

Regular classes in school? Yes No
IEP? Yes No
504 plan? Yes No
Does our child have any learning disabilities? Yes No
If yes, describe ____