Dr. Robert C. Cantu Concussion Center
Emerson Hospital

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

PATIENT ID

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:

	Arm Numbness		Blind Spots		ADD/ADHD
	Arm Pain		Hearing Impairment		Anxiety/Nervousness
	Arm Weakness		Vision Impairment		Depression
	Assisted Walking		Disorientation		Dyslexia
	Back Pain		Dizziness		Other Psychiatric Disorders
	Bowel/Bladder Problems		Double/Blurred Vision		Panic Attacks
	Buttocks Pain		Face Weakness		Personality Change
	Constipation		Flashing Lights		Seizure Disorders
	Diarrhea		Headache		Sleep Disorders
	Difficulty Walking		Loss of Consciousness		Tremor
	Imbalance		Memory Change		Other Learning Disabilities
	Leg Pain		Migraine Headaches		
	Leg Weakness		Ringing in the ears		Other:
	Neck Pain		Trouble Swallowing		
			Trouble Talking		

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

How many concussions have you had? #_____ Date of Most Recent Concussion: _____

Have you ever been diagnosed with a concussion or had your "bell rung" or had symptoms in the check off list you completed after a hit? Yes No

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: _____

CLI−000−00014
Reviewed and Approved 10/12/2016

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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? #_____

Do you have children? Yes No If yes, what are their ages: _____

List major operations: _____

_____

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

Have you had a history of any of the following? Please check any that apply:

	Alcoholism		Gynecological Problems		Migraine Headaches
	Anorexia/Bulimia		Gallstones		Osteoporosis
	Bleeding/Bruising		GI Problems (GERD, reflux, heartburn)		Seizures
	Blood Clots		Glaucoma		Sexually Transmitted Disease
	Blood Disorder/Anemia		Heart Problems		Significant weight gain
	Breast Problems		High Blood Pressure		Skin Problems
	Cancer		HIV/AIDS		Stroke
	Chills/Fever		Joint pain/arthritis		Thyroid Disease
	Depression		Kidney Disease		Tick Bites
	Diabetes		Liver Disease or Hepatitis		Ulcers
	Drug Abuse		Lung Problems (including Asthma)		Other:
	Elevated Cholesterol		Mental Illness		

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

If yes, who is your attorney? _____

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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:	

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

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

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