ImPACT APPLICATIONS, INC.
ConcussionManagement.com

Demographic and Background Information

Test Language: _____

First Name: _____ Last Name: _____

Date of Birth: _____Month _____ Date _____Year

Gender: _____ Male _____ Female

Pointing Device: _____ Mouse _____ Trackpad _____ Unsure

Have you ever been diagnosed with attention deficit disorder or hyperactivity? _____ Yes _____ No

Have you ever been diagnosed with a learning disability? _____ Yes _____ No

Have you had a concussion in the last 6 months? _____ Yes _____ No

Native Country / Region: _____

Native Language: _____

Second Language: _____ (only if fluent in speaking and writing)
Years of education completed excluding kindergarten: _____
(e.g., high school senior is 11 years)
Check any of the following that apply:

_____ Received speech therapy
_____ Attended special education classes
_____ Repeated one or more years of school

While in school, what type of student were / are you?
_____Below Average _____Average _____Above Average

Current Sport: _____

Current position / event / class: _____
(e.g., quarterback, forward, 1st base, etc.)

Current level of participation: _____(e.g., junior high, high school)

Years of experience at this level: _____ (0 - 4)
(e.g., number of years in high school, high school senior = 3)

Demographic and Background Information

Concussion History

_____ Number of times diagnosed with a concussion (excluding current injury)
_____ Total number of concussions that resulted in loss of consciousness
_____ Total number of concussions that resulted in confusion
_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately after injury
_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately before injury
_____ Total number a games that were missed as a direct result of all concussions combined

Indicate whether you have been treated for the following:

_____ Yes _____No Headaches by physician
_____ Yes _____ No Migraine headaches by physician
_____ Yes _____ No Epilepsy / seizures
_____ Yes _____ No Brain surgery
_____ Yes _____ No Meningitis
_____ Yes _____ No Substance abuse / alcohol abuse
_____ Yes _____ No Psychiatric condition (depression, anxiety)

Have you been diagnosed with any of the following?

_____ Yes _____ No Dyslexia
_____ Yes _____ No Autism

Have you participated in any strenuous exercise and/or exertion in the last three hours? _____ Yes _____ No

Date of your last concussion: _____ month _____ date _____ year

Hours of sleep last night (approximate if uncertain): _____

Please list any **PRESCRIPTION** medication(s) you are currently taking:

_____

_____

_____