



Sports Concussion Center of New Jerseysm

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DATA FORM FOR BASELINE/NEUROPSYCHOLOGICAL CONCUSSION TESTING (CONFIDENTIAL)

Name _____
Address _____

Phone (home) _____
Phone (work/cell) _____
Marital Status _____
Spouse or Parents' Names _____

Today's Date _____
Age _____ Gender _____
Birthdate _____ Yrs. of Educ. _____
S.S. # _____
School and Grade or Employer (address & phone) _____

Referred by: _____

Emergency Contact (name & phone #) _____

Sports Teams/ Activities presently involved in:

<u>Team/Activity Name</u>	<u>Location/Address</u>	<u>Season</u>	<u>Coach/Contact</u>

Family Physician (name, address, phone #) _____

Any Known History of Medical Conditions from Birth until the Present (include hospitalizations, surgeries, accidents, broken bones, substance abuse): _____

Concussions/Head Injuries History (age & dates) _____

Present Medications _____

Any Known History of Learning/Attention Disorders, Dyslexia, Academic Difficulties/Retention, Child Study Team Classifications, etc. _____

Estimated Grade Point Average for most recent school year: _____ (A=4.0, B=3.0, C=2.0, D=1.0)

Estimated School Standardized Testing Percentiles for English/Verbal _____% for Math _____%

History of Counseling or Therapy (briefly describe) _____

Anything else you think we should know? _____