Sports Concussion Center of New Jersey[sm]

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IMPACT BASELINE QUESTIONNAIRE

Name: _____ Date of Birth: _____
Gender: _____ Handedness: _____
Height: _____ft_____in Weight (pounds):_____
Native Country: _____ Native Language: _____
Phone: _____

Educational History

Current grade in school: _____

Have you ever received any of the following? (Please circle Y or N)

Speech Therapy?	Y	N
Attended Special Education Classes?	Y	N
Repeated one or more years in school?	Y	N
Diagnosis of a learning disability?	Y	N
Diagnosis of ADHD?	Y	N

How would you describe yourself as a student?
Below Average_____ Average _____ Above Average_____

Sport and Medical History

Current Sport:_____ Current Position:_____
Number of years playing:_____
Number of times diagnosed with a concussion: _____
List dates of five most recent concussions: _____

Please answer the following questions:

Are you colorblind?	Y	N
Have you been treated for headaches by a physician?	Y	N
Have you been treated for migraine headaches by a physician?	Y	N
Do you have a history of Epilepsy/seizures?	Y	N
Do you have a history of brain surgery?	Y	N
Do you have a history of meningitis?	Y	N
Have you received treatment for alcohol/substance abuse?	Y	N
Have you received treatment for a psychiatric condition (depression, anxiety)?	Y	N