

# Andover Pediatrics Concussion Patient History Intake Form

**Patient Name:**.....  
**Date:**.....  
**Date of Injury:**.....  
**Position Played:**.....  
**Team:**.....

	Yes	No
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?	<input type="checkbox"/>	<input type="checkbox"/>

If so, when?.....

Have you ever lost consciousness as a result of a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized as a result of a head injury?	<input type="checkbox"/>	<input type="checkbox"/>

Where?.....  
 Details.....  
 .....

Have you ever had any imaging studies done of your brain?	<input type="checkbox"/>	<input type="checkbox"/>
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Where?.....  
 Details.....  
 .....

Date of most recent concussion.....

Date of most recent imaging studies.....

Additional Risk Factors – Personal History	Yes	No
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>

Additional Risk Factors – Personal History (cont.)	Yes	No
Other learning disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
Other psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Are you on any medications? Please list.....	<input type="checkbox"/>	<input type="checkbox"/>

## Family History

Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>
Other learning disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
Other psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>

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