Stony Brook Medicine

Department of Neurology

Adult (Age 15 and up) Concussion New Patient

Patient Name: _____

Date of Injury: _____

Work/School: Full time Part Time Where: _____

Language(s) other than English spoken in home: _____

Mechanism of Injury _____

_____

Loss of Consciousness? Yes No Do you recall impact? Yes No

Were you removed from sport/play due to injury? Yes No

Please list ALL concussion dates and length of recovery: _____

_____

_____

Indicate whether you had any of the following (Circle one):

Chronic Headaches (non-concussion related)? Yes No

Chronic Migraines Yes No

Epilepsy/Seizures Yes No

Brain Surgery Yes No

Sleep Disorder (ex: Insomnia, Sleep Apnea) *If yes, What type?* _____ Yes No

Meningitis Yes No

Substance Abuse/ETOH Abuse Yes No

Mental Health Condition (anxiety, depression etc.) Yes No

If yes, which type(s)?: _____

Family History of any of the above: Yes No
If yes, which ones(s)? _____

Past Medical History:_____

Past Surgical History:_____

Family History:_____

Drug Allergies:_____Food Allergies:_____Diet:_____

Have you tested positive at any point for COVID-19? Yes No; If yes, when? _____

Have you ever been diagnosed with ADD/ADHD? Yes No

Have you ever been diagnosed with Dyslexia? Yes No

Have you ever been diagnosed with Autism? Yes No

Have you ever been diagnosed with a learning disability/issue(s)? Yes No

If yes, what type? _____

Have you received Speech Therapy? Yes No

Did you had an IEP/504 plan in school? Yes No

Have you repeated one or more years of school? Yes No

Military Service? Yes No

Did you play a sport in College? Yes No

If Yes; what sport(s):_____

When in school, what type of student were/are? A's & B's B's and C's C's & D's D's and F's

What year did you graduate from High School? _____; Where:_____

Did you attend College? Yes No Some College; (list all degrees)

Where:_____ Degree:_____

Where:_____ Degree:_____

Alcohol: None Yes How much/often_____

Tobacco: Never Yes How much/long_____

Marijuana: None Yes How much_____

Recreational Drugs: None Yes Which ones:_____

Medications:_____

Vitamins/Herbals:_____

Sleep: How Many Hours:_____Trouble Falling Asleep: No Yes Wake up frequently: No Yes

Screen Time: How Many Hours:_____

Please circle the early signs that were reported after the injury:

Headache	Appeared dazed/confused	Sensitivity to light	Sensitivity to noise
Balance issues	Confused about events	Dizziness	Fogginess
Irritability	Answered questions slowly	Visual Changes	Forgetful
Neck pain	Repeated questions	Nausea	Vomiting

Where was the location of your impact?

No head impact Front of head Back of head Left side of head

Right side of head Unsure

Who have you been evaluated by?

Primary Care Physician Athletic Trainer Emergency Center Urgent Care

Other/Physician/NP/PA

Who recognized that you had a concussion?

Athletic trainer Coach Self Spouse Parent Teacher Teammate Other: _____

Have you returned to work?

Full day Half Day Not Working

Have you returned to any Physical activity/Exercise after the injury? Yes No

Have you had any imaging (ex: MRI, CT scan)? Yes No

If yes, what type: _____

Where? _____

If applicable: What was the first day of your last period? _____

If applicable: How many periods have you had in the last 12 months? _____

If applicable: What age were you at your first period? _____

Symptoms Today	0 (None)	1 (Mild)	2	3 Mode	4 rate	5	6 (Severe)
Headaches	0	1	2	3	4	5	6
Pressure in Head	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sensitivity to Light	0	1	2	3	4	5	6
Sensitivity to Sound	0	1	2	3	4	5	6
Feeling like “in a fog”	0	1	2	3	4	5	6
Difficulty Concentrating	0	1	2	3	4	5	6
Difficulty Remembering	0	1	2	3	4	5	6
Fatigue/Low Energy/Slowed Down	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
More Emotional	0	1	2	3	4	5	6
More Irritable	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous/Anxious	0	1	2	3	4	5	6

Sleep Disturbance	0	1	2	3	4	5	6
Abnormal Heart Rate	0	1	2	3	4	5	6
Excessive Sweating	0	1	2	3	4	5	6
Do symptoms worsen with physical activity?	0	1	2	3	4	5	6
Do symptoms worsen with cognitive (thinking) activity?	0	1	2	3	4	5	6
How normal (your baseline) do you feel?	0	1	2	3	4	5	6

Have you had any other symptoms/injuries in association with you head injury not reported above?

Loss of appetite w/o Nausea Indigestion Weight Loss Ringing in the ear

Neck Pain Back Pain Speech Issues Feeling Clumsy Skull Fracture

Brain Bleed Seizure Pain in arm, legs or joints Chest pain Ear Pain

Stomach or Bowel Problems Other: _____

PHQ-9 Depression Screening

Over the **last 2 weeks**, how often have you been bothered by any of the following	Not at	Several	More than half of the	Nearly Every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed or being so fidgety/restless that you have been moving around a lot more than	0	1	2	3

Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

GAD-7 Anxiety Screening

Over the **last 2 weeks**, how often have you been bothered by any of the following	Not at	Sever al	More than half of the	Nearly Every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

MIDAS

Please answer the following questions about ALL of the headaches you have had over the **last 3 months.** Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months.

_____1. On how many days in the last 3 months did you miss work or school because of your headaches?

_____2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

_____3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

_____4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

_____5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

Total Score: 0-5 6-10 11-20 21+

Pittsburgh Sleep Quality Index

During the past week how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)	
5 to 6 hours	4
6 to 7 hours	3
7 to 8 hours	2

8 to 9 hours	1
More than 9 hours	0
How satisfied/dissatisfied were you with the quality of your sleep?	
Very dissatisfied	4
Somewhat dissatisfied	3
Somewhat satisfied	2
Satisfied	1
Very satisfied	0
During the recent past, how long has it usually taken you to fall asleep at each night?	
Longer than 60 minutes	3
31-60 minutes	2
16-30 minutes	1
15 minutes or less	0
How often do you have trouble staying asleep?	
Five to seven times a week	3
Three or four times a week	2
Once or twice a week	1
Never	0
During the recent past, how often have you taken medicine to help you sleep? (prescribed or over the counter)	
Five to seven times a week	3
Three or four times a week	2
Once or twice a week	1
Never	0