Stony Brook Children's
STONY BROOK LONG ISLAND CHILDREN'S HOSPITAL

Department of Neurology

PEDIATRIC CONCUSSION INTAKE FORM

Patient Name: _____

Date of Injury: _____ School: _____ Grade: _____

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

Sport(s):_____ Position in Sport(s):_____

Mechanism of Injury _____

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

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

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

Answer the following Questions please (circle one):

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

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

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

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When in school, what type of student were/are? Below Average Average Above Average

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) Yes No

*If yes, What type?*_____

Meningitis Yes No

Substance Abuse/ETOH Abuse Yes No

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

If yes, which type(s)? _____

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

Headache	Appeared dazed/confused	Sensitivity to light	Sensitivity to noise
Balance issues	Is confused at 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?

Pediatrician Athletic Trainer Emergency Center Urgent Care Other Physician/NP/PA

Who recognized that you had a concussion?

Athletic trainer Coach Self Parent School Nurse Teacher Teammate Other:_____

Have you returned to school?

Full day Half Day Not in school

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? _____

What was the first day of your last period? _____ N/A _____

How many periods have you had in the last 12 months? _____ N/A: _____

What age were you at your first period? _____ N/A: _____

PHQ-9 Depression Screening

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several Days	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 much	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 usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

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: _____

GAD-7 Anxiety Screening

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several Days	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+