## Jefferson Pediatrics

Concussion Evaluation

Name:

DOB:

Date:

1. Cause of injury and description of how it happened

2. Loss of consciousness, amnesia (before and after injury), or seizures? (Circle all that apply)
3. Is forgetful, dazed, confused, answers questions slowly, repeats questions? (Circle all that apply)
4. Headache, N/V, dizziness, visual problems, phonophobia, photophobia, or numbness/tingling? (Circle all that apply)
5. Feels mentally foggy, feeling slowed down, difficulty concentrating, difficulty remembering? (Circle all that apply)
6. Is irritable, sad, more emotional, or has nervousness? (Circle all that apply)
7. Is drowsy, sleeping more or less than usual; sleeping _____hours, or trouble falling asleep? (Circle all that apply)
8. Previous concussions? If so, how many and how long did symptoms last? Currently has a headache? Characteristics?