PROVIDENCE
St. Mary
Neuroscience Institute

Concussion and Health History Questionnaire

Name:_____Today's Date:_____

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

PCP:_____ Referring Provider:_____

Why are you seeing the doctor today?_____

_____

Please list any major complaint(s) and describe their onset (i.e., headache began in last week after hitting head playing football):

_____

_____

Is this visit related to an on the job injury? □Yes □No

If so, date of injury: _____ Date of last employment:_____

Do you have any open worker's compensation claims of any kind? □Yes □No

Do you have a lawsuit pending? □Yes □No

Previous physicians seen for this problem?

Physician	Specialty	City	Treatment

Time and date of injury: _____

Cause: ____MVC _____Pedestrian-MVC_____Fall _____Assault _____Sports_____ (*specify)* Other_____

Where was the location of impact to the head: _____

Amnesia Before (Retrograde) Are there any events just BEFORE the injury that you have no memory of (even brief)?

__ Yes __No Duration _____

Amnesia After (Anterograde) Are there any events just AFTER the injury that you have no memory of (even brief)?

__ Yes __No Duration _____

Loss of Consciousness: Did you lose consciousness? __ Yes __No Duration: _____

Early signs (Did you have any feelings of): ☐Feeling dazed or stunned

☐Feeling confused about events ☐Answering questions slowly ☐Repeating Questions ☐Forgetful (recent info)

Seizures: Were seizures observed? No__ Yes___

Details_____

Pain: Please circle the description which applies to your intensity of pain

Unchanged	Gradually worsening	Rapidly worsening	Stable
Gradually improving	Rapidly improving	Completely resolved	

Symptom Check List: Please circle all that apply

Since the injury, have you experienced any of these symptoms any more than usual today or in the past day?

PHYSICAL	COGNITIVE	SLEEP	EMOTIONAL
Headache	Feeling mentally foggy	Drowsiness	Irritability
Nausea	Feeling slowed down	Sleeping more than usual	Sadness
Vomiting	Difficulty concentrating	Sleeping less than usual	Feeling more emotional
Balance problems	Difficulty remembering	Trouble falling asleep	Nervousness
Dizziness			
Visual problems			
Fatigue			
Sensitivity to light			
Sensitivity to sound			
Numbness/tingling			

Are your symptoms worsened by physical activity? Yes_____ No_____

Are your symptoms worsened by cognitive activity? Yes_____ No_____

Have you experience any previous concussions? Yes_____ No_____

If yes, how many and at what age(s):_____

After previous concussion how long was the longest symptom duration:

Days_____Weeks_____Months_____Years_____

Do you have a history of developmental issues?

Learning disabilities_____ Attention-Deficit/Hyperactivity Disorder_____

Other Developmental disorders_____

Do you have any history of Psychiatric Disorders? Anxiety_____ Depression_____

Sleep Disorders _____ Other Psychiatric disorders_____

Do you have and family history of Parkinson's or Alzheimer's disease? _____

Do you have any family history of Migraines? _____

Do you have a prior history of headaches? □ Yes □ No, If NO please skip questions 1-14

Headaches: please answer all that apply to your situation

1. Onset of headache:

□ Recently started (dates) _____

□ Since childhood (dates) _____

□ Since the age of _____years old

□ For about the last _____days/weeks/months/years

□ Following head injury, trauma, or motor vehicle accident which occurred on (date)_____

2. Location of headache:

□ Frontal (forehead) □ Parietal (side of head) □ Band-like (surrounding head)

□ Occipital (neck) □ Temple □ Orbital (around the eyes) □ Retro-orbital (behind the eyes)

3. Does headache occur on:

□ One side (right or left) □ Radiates from neck to forehead □ Both sides

□ Involves entire head □ Shifts from side to side □ Other _____

Do you feel you have more than one type of headache: □ Yes □ No

If yes, _____

_____

_____

4. Frequency of headaches:

□ Daily □ Almost daily □ Intermittent throughout the day

□ Approximately how many times _____per day/week/month/year (circle one)

5. Severity of headache:

□ Mild

□ Mild to moderate

□ Moderate

□ Moderate-severe

□ Severe

□ Is the headache aggravated with bending over, walking, climbing stairs, or activity

□ Do you have to lie down in a quiet dark room on occasions?

□ Lying down makes headache worse?

□ Do you ever miss work/school because of headache?

6. Duration of headache:

□ Constant in nature

□ Last approximately _____ minutes/hours/days

□ Goes away in _____minutes/hours if treated immediately with (name of medication) _____

7. Timing of headache:

□ Starts mild and progress to severe within _____minutes/hours/days (circle one)

□ Severe at onset

8. Quality of headache: How would you best describe your headaches? Please check all that apply.

□ Band-like □ Sharp □ Dull achiness

□ Stabbing □ Constant headache □ Squeezing

□ Piercing □ Throbbing □ Pinching

□ Vice-like □ Pounding □ Pressure

□ Pulsating □ Feels like head is going to explode

□ Feels like someone is squeezing your head □ Other_____

9. Situation: Do the headaches awake you from sleep? □Yes □ No

If yes, any special time after falling asleep:_____

_____

_____

10. Prodrome: Do you notice any of the following symptoms 1-3 days prior to the onset of the headache?

□ Mood changes such as anxiety or depression □ Fatigue

□ Food craving □ Increased urination

□ Increased thirst □ Cervical stiffness or pain

□ Loss of appetite □ Other_____

11. Aura: Do you have vision changes that occur within 1 hour to the onset of the headache? □ Yes □No

If yes, do you see?

□ Spots □ Visual blurring

□ Illusions of distorted size/shape □ Simmering or wavy lines

□ Facial or upper extremity numbness and/or tingling □ Zig zag patterns

□ flashes of light □ Partial visual field loss

12. Symptoms: Which symptoms accompany your headache?

□ None □ Nausea □ Lightheadedness/dizziness

□ Vomiting □ Slurred speech □ Difficulty with memory/concentration

□ Pacing □ Tenderness to temples □ Hair and/or scalp ache

□ Jaw tightness □ Nasal congestion □ Muscle achiness

□ Fever □ Diarrhea □ Neck tightness/stiffness

□ Tearing/watering of the eye on the affected side of the head

□ Sensitive to sound/noise (sonophobia) □ Sensitive to light/brightness (photophobia)

□ Vision problems (please explain)_____

13. Headache precipitating factors/triggers: Do any of the following tend to bring on a headache?

A. Physical triggers

□ Brushing teeth
□ Coughing
□ Eating/chewing/speaking
□ Exposure to glare
□ Flickering lights
□ Fluorescent lights
□ Prolonged neck movement
□ Loud noises
□ Menstrual cycle
□ Physical activity
□ Sexual activity
□ Too much sleep
□ Too little sleep
□ Cigarette/cigar smoke
□ Other: _____

B. Food/Drink triggers

□ Alcohol
□ Bananas
□ Caffeine
□ Cheese
□ Chocolate
□ Citrus fruit
□ Monosodium glutamate (MSG)
□ Nuts

14. Headache precipitating factors/triggers: Do any of the following tend to bring on a headache?

C. Psychological Triggers

□ Family illness
□ Personal illness
□ Financial difficulties
□ Stress/tension
□ Marital status
□ Other_____

D. Seasonal/Allergy

□ Allergies to _____
□ Exposure to cold/hot weather
□ High altitude
□ High humidity
□ Other _____
□ Scented candles
□ Weather changes (rain/thunderstorms/etc.)
□ Food odors
□ Perfume

E. Occupation/work triggers

□ Chemical fumes (gas, oil, kerosene)
□ Chemical odor
□ Repetitive movement's
□ Other _____
□ None
□ Prolonged computer usage
□ Employment security (fear of being fired, lay-off
□ Work relationships/conflict

History and Physical

PAST MEDICAL HISTORY: Check all that □ None Apply

□ Abnormal heartbeat	□ Cirrhosis	□ High blood pressure	Neuropathy: □ Hands □ Feet
□ ADHD	□ Depression	□ High cholesterol	□ Poor circulation
□ Anemia	□ Down syndrome	□ HIV/AIDS	□ Seizure
□ Anxiety	□ Emphysema	□ Kidney failure	□ Spina bifida
□ Asthma	□ Gastric reflux	□ Kidney stones	□ Stomach ulcers
□ Bleeding disorder	□ Gout	□ Migraine	□ Stroke
□ Blood clots in leg	□ Heart attack	□ Multiple Sclerosis (MS)	□ Thyroid
□ Blood clots in lung	□ Heart failure	□ Neurofibromatosis	□ Tuberculosis
□ Cerebral palsy	□ Hepatitis B or C	□ Osteoporosis	□ Fibromyalgia
□ Osteoarthritis	□ Rheumatoid arthritis	□ Other Rheumatological Disease	

Cancer:_____(type and treatment)

□ Diabetes: If yes, when was it diagnosed?_____

Currently controlled with: □ Insulin □ Oral medication □ Diet

Other:_____

PAST SURGICAL HISTORY □ No prior surgery

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? □ Yes □ No

If yes, have you had any problems related to this? □ Yes □ No

Explain any problems with general anesthesia:_____

Social History: Work status

□ Working □ Homemaker □ Unemployed □ Disabled □ On leave □ Retired □ Student

Occupation: _____Education:_____

Marital status: □ Single □ Married □ Divorced □ Widowed

Children: □ No □ Yes, how many? _____

Do you live alone? □ Yes □ No If no, who lives with you?_____

Are you currently smoking? □ Yes □ No If yes, how many pack/day? _____For how many years? _____

Have you previously quit smoking? If so, when did you quit? _____How many years did you smoke? _____

How many packs a day did you previously smoke? _____Other forms of tobacco used? _____

Alcohol use: □ Never □ Rare □ Social □ Frequently (more than twice a week)

□ Alcoholic □ Recovering alcoholic

Illegal drug use:□ Never □ In the past □ Currently □ Types of drugs? ___

Do you drink caffeine? □ Yes □ No How much? _____

Sexually active: □ Yes □ No

FAMILY HISTORY: Please fill in the family member illness information below with the options listed in the table

Alcoholism	Cancer	High blood pressure	Other Rheumatological disease
Arthritis	Diabetes	Kidney problems	Seizure
Bleeding problems	Gout	Lung problems	Stroke
Blood clots	Heart problems	Mental Illness	Other

FAMILY MEMBER	ILLNESS	AGE	IF DECEASED, AGE AT DEATH AND CAUSE
Father			
Mother			
Brother(s)			
Sister(s)			
Children			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			

Family History Unknown □ Adopted □

Please rate your usual level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Patient's signature_____ Date_____

Provider's signature_____ Date_____