ORTHOPEDIC ASSOCIATES OF LONG ISLAND
PRECISIONCARE

ThinkSMART!
Concussion Management Program

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Confidential Medical History
Concussion Intake Form

Name: _____ Date of Birth: _____ Date of Injury: _____

Age: _____ Height: _____ Weight: _____ Current Sport: _____

Occupation/School: _____ Who referred you? _____

How did the injury occur? _____

_____

Did you lose consciousness? Yes No

Do you remember everything before the injury? Yes No After the injury? Yes No

Were you seen at the ER? Yes No If yes, any imaging done? MRI CT Xray None

Have you ever had a prior concussion? Yes No If yes, how many? _____ Date of most recent? _____

Do you have ADHD or any learning disability? Yes No _____

Personal or family history of anxiety/depression or other psychiatric disorder? Yes No _____

Personal or family history of headaches? Yes No _____

Do you have any other medical conditions? _____

Underline your initial symptoms. ***Circle*** your current symptoms: NONE

Headaches	Vomiting	Feeling more emotional
Nausea	Dizziness	Nervousness
Fatigue	Feeling mentally foggy	Drowsiness
Visual problems	Problems concentrating	Sleeping more
Balance problems	Problems remembering	Sleeping less
Sensitivity to light	Feeling slowed down	Trouble falling asleep
Sensitivity to noise	Irritability	
Numbness/Tingling	Sadness	

Do any of the above symptoms worsen with physical or mental exertion? Yes No

Are you currently taking any medications for the above symptoms? If yes, please list: _____

_____

Patient Name: _____ Date of Birth: _____

Medical History

Please list your medical problems, e.g., high blood pressure, diabetes, high cholesterol, depression, and any condition for which you are prescribed a medication, etc.: _____

_____

Females only – Do you think you might be pregnant at this time? □ Yes □ No

Surgical History

Have you ever had surgery? □ Yes □ No If yes, please describe: _____

_____

Family History

Please list the medical problems of your immediate family, e.g., arthritis, bleeding problems, cancer, diabetes, heart disease, high blood pressure, neurologic problem, osteoporosis, etc.:

Mother: _____

Father: _____

Sibling(s): _____ □ Not applicable

Social History

Marital status: □ Single □ Married □ Partner □ Divorced □ Widowed

Do you have children? □ Yes □ No If yes, how many? _____

Are you currently employed? □ Yes □ No □ Retired

If yes, please list your employer and occupation: _____

Do you use tobacco? □ Yes □ No If yes, how much and how often? _____

Do you use alcohol? □ Yes □ No If yes, how much and how often? _____

Before your current injury/symptoms, please describe your typical physical activity: _____

_____

Are there any upcoming events that may affect your treatment plan, e.g., race, competition, travel?

_____

Medications

Please list your current medications, both prescription and over-the-counter: _____

_____

Please list any supplements that you take regularly: _____

Allergies

What medications are you allergic to? _____

Are you allergic to contrast dyes? □ Yes □ No Are you allergic or sensitive to latex? □ Yes □ No

Patient Name: _____ Date of Birth: _____

Review of Systems

Check any symptom below that you are currently experiencing or have experienced in the past weeks:

Abdominal pain	□ Yes	□ No	Glasses	□ Yes	□ No
Anxiety	□ Yes	□ No	Headache	□ Yes	□ No
Balance problem	□ Yes	□ No	Hearing loss	□ Yes	□ No
Blood in urine	□ Yes	□ No	Hot flashes	□ Yes	□ No
Blurry vision	□ Yes	□ No	Immune system issue	□ Yes	□ No
Bowel incontinence	□ Yes	□ No	Insomnia	□ Yes	□ No
Cellulitis (infection)	□ Yes	□ No	Irregular heartbeat	□ Yes	□ No
Chest pain	□ Yes	□ No	Joint pain	□ Yes	□ No
Cold intolerance	□ Yes	□ No	Joint stiffness	□ Yes	□ No
Constipation	□ Yes	□ No	Muscle aches	□ Yes	□ No
Contacts	□ Yes	□ No	Nose bleeds	□ Yes	□ No
Coordination problem	□ Yes	□ No	Pain with urination	□ Yes	□ No
Cough	□ Yes	□ No	Rash	□ Yes	□ No
Depression	□ Yes	□ No	Ringing in ears	□ Yes	□ No
Diarrhea	□ Yes	□ No	Seasonal allergies	□ Yes	□ No
Double vision	□ Yes	□ No	Seizure	□ Yes	□ No
Easy bleeding	□ Yes	□ No	Shortness of breath	□ Yes	□ No
Easy bruising	□ Yes	□ No	Sore throat	□ Yes	□ No
Eating disorder	□ Yes	□ No	Urinary incontinence	□ Yes	□ No
Excessive thirst	□ Yes	□ No	Weight gain	□ Yes	□ No
Fatigue	□ Yes	□ No	Weight loss	□ Yes	□ No
Fever/chills	□ Yes	□ No	Wheezing	□ Yes	□ No

What goals do you have for today's visit? _____

_____

Is there anything else that you would like your care team to know about you? _____

_____

Would you like today's note to be sent to another physician? □ Yes □ No

If yes, please complete a Medical Release form and provide your doctor's information.
The Medical Release form can be found at the front desk.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____