

Concussion Test

Patient Information:

Name:

Age:

Date of Birth:

Gender:

Contact Information:

Address:

Medical History:

Previous Concussions:

☐ Yes

☐ No

Other Head Injuries

☐ Yes

☐ No

Medical Conditions: [List any relevant medical conditions]

Medications: [List any current medications]

Symptom Checklist:

Rate the severity of the following symptoms:

0: None - No presence of the symptom or no impact on daily functioning.

1: Mild - Mild presence of the symptom with minimal impact on daily functioning.

- 2: Moderate** - Moderate presence of the symptom with a noticeable impact on daily functioning.
- 3: Severe** - Severe presence of the symptom with a significant impact on daily functioning.
- 4: Very Severe** - The very severe presence of the symptom, causing severe impairment of daily functioning.

	0	1	2	3	4
1. Headache	☐	☐	☐	☐	☐
2. Nausea/Vomiting	☐	☐	☐	☐	☐
3. Dizziness	☐	☐	☐	☐	☐
4. Balance Problems	☐	☐	☐	☐	☐
5. Blurred Vision	☐	☐	☐	☐	☐
6. Sensitivity to Light	☐	☐	☐	☐	☐
7. Sensitivity to Noise	☐	☐	☐	☐	☐
8. Fatigue	☐	☐	☐	☐	☐
9. Sleep Disturbances	☐	☐	☐	☐	☐
10. Difficulty Concentrating	☐	☐	☐	☐	☐
11. Memory Problems	☐	☐	☐	☐	☐
12. Irritability	☐	☐	☐	☐	☐
13. Anxiety/Depression	☐	☐	☐	☐	☐

(Insert Scale on the right side from 0 - 4)

Neurological Examination

	0	1	2	3	4
1. Cranial Nerves Assessment					
Eye Movements:	☐	☐	☐	☐	☐
Facial Sensation and Strength:	☐	☐	☐	☐	☐
Hearing and Balance:	☐	☐	☐	☐	☐
2. Motor Function Assessment					
Muscle Strength:	☐	☐	☐	☐	☐
Coordination:	☐	☐	☐	☐	☐
3. Sensory Function Assessment					
Touch Sensation:	☐	☐	☐	☐	☐
Proprioception:	☐	☐	☐	☐	☐

Cognitive Assessment

1. Orientation

- Time:
- Place:
- Person:

2. Memory

- Immediate Recall:

- Short-Term Memory:
- Long-Term Memory:

3. **Attention and Concentration**

- Digit Span:
- Serial Subtraction:

4. **Language**

- Naming Objects:
- Fluency:

5. **Executive Function**

- Planning and Problem-Solving:
- Cognitive Flexibility: