

**LEHIGH VALLEY INSTITUTE FOR SPORTS  
AND MUSCULOSKELETAL MEDICINE**

**THE CONCUSSION CENTER**

**DEMOGRAPHIC AND BACKGROUND INFORMATION**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

School/Organization \_\_\_\_\_

Handedness: Right or Left or Both (circle one) Gender: Male or Female (circle one)

Native Language \_\_\_\_\_

Years of Education Completed (e.g. H.S. Senior = 11) \_\_\_\_\_

Check any of the following that apply:

- \_\_\_ Received speech therapy
- \_\_\_ Attended special education classes
- \_\_\_ Repeated one or more years of school
- \_\_\_ Diagnosed with ADD or ADHD
- \_\_\_ Diagnosed with a learning disability

Current Sport/Activity \_\_\_\_\_

Position/Event/Class \_\_\_\_\_

Level of Participation: Junior High High School College Semi-Professional  
Professional

Years of experience at this level: \_\_\_\_\_

Number of times diagnosed with a concussion \_\_\_\_\_

\_\_\_\_ Total number of concussions that resulted in loss of consciousness

\_\_\_\_ Total number of concussions that resulted in confusion

\_\_\_\_ Total number of concussions that resulted in difficulty with memory of events occurring immediately after the injury

\_\_\_\_ Total number of concussions that resulted in difficulty with memory of events occurring immediately before the injury

\_\_\_\_ Total number of games that were missed as a result of concussions

Please list the dates (approximate) of the FIVE most recent concussions:

Have you experienced the following?

Treatment for headaches by a physician Yes/No

Treatment for migraine headaches by a physician Yes/No

Treatment for epilepsy/seizures Yes/No

History of brain surgery Yes/No

History of meningitis Yes/No

Treatment for substance/alcohol abuse Yes/No

Treatment for psychiatric condition Yes/No

Date of last concussion \_\_\_\_/\_\_\_\_/\_\_\_\_

Total hours of sleep last night \_\_\_\_\_

Current Medications: