Baseline Worksheet

I. Demographic and Background Information

Team / Organization: _____

Date of Birth: _____ month _____ date _____year

First Name: _____ Last Name: _____

Height: _____ft _____in Weight: _____ Gender: _____ male _____ female

Handedness: _____ right _____ left _____ ambidextrous (both right and left)

Native Country / Region: _____Native Language: _____

Second Language: _____ (only if fluent in speaking and writing)

Years of education completed excluding kindergarten: _____
(e.g., high school senior is 11 years)
Check any of the following that apply:

_____ Received speech therapy
_____ Attended special education classes
_____ Repeated one or more years of school
_____ Diagnosed attention deficit disorder or hyperactivity
_____ Diagnosed learning disability

While in school, what type of student were / are you?

_____ Below Average
_____ Average
_____ Above Average

Current Sport: _____

Current position / event / class: _____ (e.g., quarterback, forward, 1st base, etc.)

Current level of participation: _____ (e.g., junior high, high school)

Years of experience at this level: _____ (0 - 4) (e.g., number of years in high school, high school senior = 3)

Please list your 5 most recent concussions:

_____ month _____ year
_____ month _____ year
_____ month _____ year
_____ month _____ year
_____ month _____ year

Baseline Worksheet

I. Demographic and Background Information (cont.)

Concussion History

_____ Number of times diagnosed with a concussion (excluding current injury)
_____ Total number of concussions
_____ Total number of concussions that resulted in confusion
_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately after injury
_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately before injury
_____ Total number a games that were missed as a direct result of all concussions combined

Indicate if you have had any of the following:

_____ yes _____ no Treatment for headaches by physician
_____ yes _____ no Treatment for migraine headaches by physician
_____ yes _____ no Treatment for epilepsy / seizures
_____ yes _____ no Treatment for brain surgery
_____ yes _____ no Treatment for meningitis
_____ yes _____ no Treatment for substance abuse / alcohol abuse
_____ yes _____ no Treatment for psychiatric condition (depression, anxiety)

Have you been diagnosed with any of the following?

_____ yes _____ no ADD/ ADHD
_____ yes _____ no Dyslexia
_____ yes _____ no Autism

Have you participated in any strenuous exercise and/or exertion in the last 3 hrs?

_____ yes _____ no

Date of your last concussion: _____ month _____ date _____ year

Number of hours slept last night: _____ (approximate if uncertain)

Please list any **PRESCRIPTION** medication (s) you are currently taking:

_____
_____
_____

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II. Current Symptoms and Conditions

Please indicate the degree to which you are **CURRENTLY** experiencing or normally feel for the following symptoms:

No symptoms "0" ……. Moderate "3" ……. Severe "6"

Headache	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Nausea	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Vomiting	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Balance Problems	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Dizziness	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Fatigue	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Trouble falling asleep	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Sleeping too much	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Sleeping too little	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Drowsiness	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Sensitivity to light	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Sensitivity to noise	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Irritability	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Sadness	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Feeling nervous	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Feeling emotional	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Numbness or tingling	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Feeling "slow"	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Feeling "foggy"	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Memory Problems	____	0	____	1	____	2	____	3	____	4	____	5	____	6
Visual Problems	____	0	____	1	____	2	____	3	____	4	____	5	____	6