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ImPACT Demographic Information

PLEASE COMPLETE IN BLACK INK

Patient Name:	Date of Birth:

School / Organization: _____

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

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:

_____

_____