



Melissa Przeklasa Auth, M.D.  
30131 Town Center Drive Suite # 195  
Laguna Niguel, CA 92677  
Office: (949) 495-6100  
Fax: (949) 354-0612  
occhildneurology.com

### 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 of 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:

---

---