Student Demographics Information

In order to complete the baseline concussion testing, students must enter information about their demographics. In order to facilitate test administration, please assist your child in completing the following information to the best of your ability.

Please have the form completed and returned to school by _____DATE_____in order to make entering the information as easy as possible.

Please assist your child in completing the following information:

Birthdate:

_____ _____ _____
Month Day Year

First Name:

_____
Last Name:

_____

Height: _____ ft. _____ in.

Weight: _____ lbs.

Gender: _____ M _____ F

Handedness: _____ Right _____ Left _____ Ambidextrous (both hands)

Address:_____

City: _____ State: _____ Zip: _____

Country: _____

Email address: _____ (optional)

Native Country or region

_____

Native Language

_____

Second Language

_____

Ethnicity (optional)

_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Hispanic or Latino
_____ Native Hawaiian or other Pacific Islander
_____ White

_____

_____ Years of education completed, excluding Kindergarten (e.g. 6th grade student=5, college freshman=12)

Check any of the following that apply:

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

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

_____ Below Average
_____ Average
_____ Above Average

Current Sports:

_____ _____

_____ _____

Current position/event/class:

_____ _____

_____ _____

Current level of participation:

_____ (selection will be junior high or high school)

Years of experience at this level:
_____ (please approximate if uncertain and do not include current year; e.g. high school senior = 3)

_____

_____ 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 for events occurring immediately after injury

_____ Total number of concussions that resulted in difficulty with memory for events occurring immediately before injury

_____ Total number of games that were missed as a direct result of all concussions combined.

Please list your 5 most recent concussions, if applicable. Use approximate dates if necessary.

1._____ 4._____

2._____ 5._____

3._____

Indicate whether you have experienced the following conditions:

ADD/ADHD
_____ Yes _____ No

Dyslexia
_____ Yes _____ No

Autism
_____ Yes _____ No

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

_____ Yes _____ No (leave blank, will answer this during the test time)

Date of last Concussion

_____

Hours of sleep at night

_____ (approximate if uncertain)

Current medications:

_____ _____

_____ _____

_____ _____

Current Symptoms and Conditions

Please check the number below that indicates the degree to which you are currently experiencing the following symptoms: (How you feel the day of the test)

Headache

___ Not experiencing this symptom
___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Vomiting

___ Not experiencing this symptom
___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___6

Nausea

___ Not experiencing this symptom
___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Balance problems

___ Not experiencing this symptom
___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

_____

Please check the number below that indicates the degree to which you are currently experiencing the following symptoms: (how you feel the day of the test)

Dizziness

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Trouble falling asleep

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___6

Fatigue

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Sleeping too much

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Sleeping too little

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Sensitivity to Light

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___6

Drowsiness

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Sensitivity to Noise

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Please check the number below that indicates the degree to which you are currently experiencing the following symptoms: (how you feel the day of the test)

Irritability

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Feeling Nervous

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___6

Sadness

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Feeling Emotional

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Numbness or Tingling

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Mentally “foggy”

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___6

Feeling too Slow

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Difficulty Concentrating

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Please check the number below that indicates the degree to which you are currently experiencing the following symptoms: (how you feel the day of the test)

Memory Problems

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6

Visual Problems

___ Not experiencing this symptom

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6