# Concussion Test

## Patient Information:

**Name:** Robyn T. Chung

**Age:** 39 years old

**Date of Birth:** 6/10/1983

**Gender:** Female

**Contact Information:** 858-347-3994

**Address:** 286 Hillhaven Drive, Hollywood, California(CA), 90028

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## Medical History:

**Previous Concussions:**

☐ Yes

☑ No

**Other Head Injuries**

☐ Yes

☑ No

**Medical Conditions: [List any relevant medical conditions]**

none

**Medications: [List any current medications]**

none

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## Symptom Checklist:

**Rate the severity of the following symptoms:**

**0: None** - No presence of the symptom or no impact on daily functioning.

**1: Mild -** Mild presence of the symptom with minimal impact on daily functioning.

**2: Moderate -** Moderate presence of the symptom with a noticeable impact on daily functioning.

**3: Severe -** Severe presence of the symptom with a significant impact on daily functioning.

**4: Very Severe -** The very severe presence of the symptom, causing severe impairment of daily functioning.

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| | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| 1. Headache | ☐ | ☐ | ☐ | ☑ | ☐ |
| 2. Nausea/Vomiting | ☐ | ☐ | ☑ | ☐ | ☐ |
| 3. Dizziness | ☑ | ☐ | ☐ | ☐ | ☐ |
| 4. Balance Problems | ☐ | ☑ | ☐ | ☐ | ☐ |
| 5. Blurred Vision | ☐ | ☐ | ☑ | ☐ | ☐ |
| 6. Sensitivity to Light | ☐ | ☐ | ☐ | ☑ | ☐ |
| 7. Sensitivity to Noise | ☐ | ☐ | ☐ | ☑ | ☐ |
| 8. Fatigue | ☐ | ☐ | ☑ | ☐ | ☐ |
| 9. Sleep Disturbances | ☐ | ☑ | ☐ | ☐ | ☐ |
| 10. Difficulty Concentrating | ☐ | ☐ | ☐ | ☑ | ☐ |
| 11. Memory Problems | ☐ | ☐ | ☑ | ☐ | ☐ |
| 12. Irritability | ☐ | ☐ | ☐ | ☑ | ☐ |
| 13. Anxiety/Depression | ☐ | ☐ | ☑ | ☐ | ☐ |

(Insert Scale  on the right side from 0 - 4)

## Neurological Examination

| | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| **1. Cranial Nerves Assessment** | | | | | |
| Eye Movements: | ☐ | ☐ | ☐ | ☑ | ☐ |
| Facial Sensation and Strength: | ☐ | ☐ | ☑ | ☐ | ☐ |
| Hearing and Balance: | ☐ | ☐ | ☐ | ☑ | ☐ |
| **2. Motor Function Assessment** | | | | | |
| Muscle Strength: | ☐ | ☐ | ☑ | ☐ | ☐ |
| Coordination: | ☐ | ☐ | ☑ | ☐ | ☐ |
| **3. Sensory Function Assessment** | | | | | |
| Touch Sensation: | ☐ | ☐ | ☑ | ☐ | ☐ |
| Proprioception: | ☐ | ☐ | ☑ | ☐ | ☐ |

## Cognitive Assessment

1. **Orientation**
   - Time: Patient correctly identifies the current time.
   - Place: Patient correctly identifies the current time.
   - Person: Patient correctly identifies their own name and other relevant personal information.
2. **Memory**
   - Immediate Recall: Patient successfully recalls a list of three given objects immediately after presentation.

- Short-Term Memory: Patient accurately recalls a list of three given objects after a short delay.
- Long-Term Memory: Patient correctly answers questions regarding personal events or information from the past.

3. **Attention and Concentration**
   - Digit Span: Patient accurately repeats a series of numbers forward and backward.
   - Serial Subtraction: Patient correctly performs serial subtraction tasks (e.g., subtracting 7 from 100) without errors.
4. **Language**
   - Naming Objects: Patient correctly names common objects presented visually or verbally.
   - Fluency: Patient generates words within a given category (e.g., animals) in a set time frame.
5. **Executive Function**
   - Planning and Problem-Solving: Patient demonstrates the ability to plan and execute a sequence of steps to solve a simple problem.
   - Cognitive Flexibility: Patient shows adaptability in switching between tasks or responding to changing instructions.