Concussion Test

Patient Information:

Name:

Age:

Date of Birth:

Gender:

Contact Information:

Address:

Medical History:

Previous Concussions:

☐ Yes

☐ No

Other Head Injuries

☐ Yes

☐ No

Medical Conditions: [List any relevant medical conditions]

Medications: [List any current medications]

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.

	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:
   - Place:
   - Person:
2. **Memory**
   - Immediate Recall:

- Short-Term Memory:
- Long-Term Memory:

3. **Attention and Concentration**
   - Digit Span:
   - Serial Subtraction:
4. **Language**
   - Naming Objects:
   - Fluency:
5. **Executive Function**
   - Planning and Problem-Solving:
   - Cognitive Flexibility: