NEWTON-WELLESLEY HOSPITAL

Department of Rehabilitation Concussion Intake Form

IDENTIFYING INFORMATION

Date:_____ Phone#: (H)_____

Name:_____ (C)_____

Address:_____ Age: _____

_____ Date of Birth: _____

*Name of Person Completing Form (if not patient):*_____

BACKGROUND INFORMATION

Please answer the following questions about your injury/illness:

1. Date of injury/illness: _____

2. Did you lose consciousness? Yes/No

   Approximate length of time unconscious: _____

3. Do you remember the accident and/or events immediately around the injury/illness? Yes/No

   Comments: _____

4. Were you hospitalized? Yes/No

   Comments: _____

5. CT or MRI results (if applicable):

   Comments: _____

6. Cause of injury: (check all that apply)

☐ Motor vehicle accident	☐ Work related	☐ Stroke
☐ Bike accident	☐ Sports	☐ Aneurysm
☐ Pedestrian	☐ Hit by falling object	☐ Other
☐ Fall	☐ Assault	

7. Prior to this injury, have you ever had a concussion or other neurological event? Yes/No

   Comments: _____

8. Who are the providers most involved in managing your concussion?

   _____

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Development and Medical History:

1. Are you left or right handed? Left/Right

2. Do you have any difficulty with hearing? Yes/No

   Comments: _____

3. Do you have any difficulty with vision? Yes/No

   Comments: _____

4. Have you ever been diagnosed with a learning disability? Yes/No

   Comments: _____

Social History:

1. Who lives in your household?

   _____

2. Has your living situation changed since your injury?

   _____

3. What is the highest level of education you have completed?

   _____

4. Most recent employer?

   _____

   Job responsibilities (full-time/part-time):

   _____

5. What activities were you involved in prior to your injury? (e.g. hobbies, sports, volunteering, etc.)

   _____

6. Has your ability to participate in these activities changed since your accident? Yes/No

   Comments: _____

7. Have you ever been treated for depression? Yes/No

   Comments: _____

THE RIVERMEAD POST-CONCUSSION SYMPTOMS QUESTIONNAIRE

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. **As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom, please circle the number closest to your answer.**

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

	Not experienced at all	**No more of a problem**	**A mild problem**	**A moderate problem**	**A severe problem**
Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset with loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4
Are you experiencing any other difficulties?					
1.	0	1	2	3	4
2.	0	1	2	3	4

ACTIVITY RATING SCALE

Please indicate (by √) if you are having difficulty now with the following activities compared to before your injury:

Home:		Comments:
1. Preparing meals		
2. Housecleaning		
3. Managing finances		
4. Listening to radio/watching TV		
5. Following conversations		
6. Talking on the phone		
7. Laundry		
8. Gardening/Yard work		
9. Parenting/Caring for family members		
10. Self care		
11. Entertaining		
12. Other:		

Community		Comments:
1. Driving		
2. Following directions/using a map		
3. Attending activities/functions with children		
4. Eating in restaurants		
5. Socializing in groups		
6. Grocery shopping		
7. Errands		
8. Using ATM/Banking		
9. Keeping appointments		
10. Automobile repairs and maintenance		

11. Using public transportation		
12. Other:		

Work/School:		Comments:
1. Following schedule		
2. Initiating tasks		
3. Reading complex material		
4. Remembering what needs to be done		
5. Completing work in a timely manner		
6. Working in presence of distractions		
7. Socializing in groups		
8. Making or keeping appointments		
9. Getting along with co-workers		
10. Maintaining stamina		
11. Composing written documents		
12. Working on a computer		
13. Other:		

Therapy Goals:
What are your goals/hopes for our work together?

_____

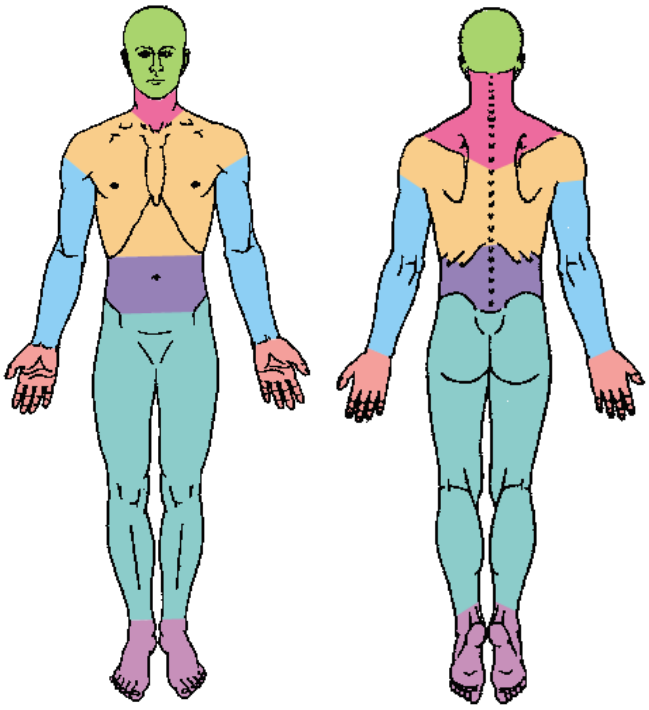
_____

_____

PAIN DIAGRAM AND RATING

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Be VERY precise when drawing the location of your pain. Use the key to indicate the type of symptoms

Key: Pins and Needles = 000000 Stabbing = ////////// Burning = xxxxxx Deep Ache = zzzzzz



Please rate your *current* level of pain on the following scale (check one)

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your *worst* level of pain in the last 24 hours on the following scale (check one)

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your *best* level of pain in the last 24 hours on the following scale (check one)

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Do you have dizziness, spinning, or vertigo? Yes/No

If Yes, please complete the following Dizziness Handicap Inventory:

Dizziness Handicap Inventory

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

1. Does looking up increase your problem?	Yes	Sometimes	No
2. Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
3. Do quick movements of your head increase your problem?	Yes	Sometimes	No
4. Does turning over in bed increase your problem?	Yes	Sometimes	No
5. Does bending over increase your problem?	Yes	Sometimes	No