Office use only:
Date:_____

Exam Room:_____

Moderator:_____

Alt.ID# _____

Baseline Worksheet

Preferred test language (please circle one or write in):
English / Spanish / Other: _____

I. Demographic and Background Information

General Information

School Name_____

Date of Birth _____

Name_____

Gender: Male *or* Female **Handedness:** R *or* L *or* Both

Parent email address to send ImPACT completed test info:

_____

Language

Native Country _____

Native Language_____

Ethnicity *optional

Check one:

- ☐ **American Indian or Alaska Native**
- ☐ **Asian**
- ☐ **Black or African American**
- ☐ **Hispanic or Latino**
- ☐ **Native Hawaiian or Other Pacific Islander**
- ☐ **White**

Education

Current Grade (Please circle):

6th 7th 8th High School - FR / SO / JR / SR College - FR / SO /JR /SR

Test Administrator: Please enter completed grade i.e. if they circle FR enter 8 in ImPACT.

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

Sports

Current Sport & Extracurricular Activities:

_____

position/ event/ class_____

level of participation_____

(e.g.: high school, semi-professional, collegiate etc)

years of experience at this level:_____

(approximate if needed; e.g., high school senior is 3 years)

Concussion History

Number of times diagnosed with a concussion: _____

- ☐ Total number of concussions that have resulted in loss of consciousness
- ☐ Total number of concussions that resulted in confusion.
- ☐ Total number of concussions that resulted in difficulty with memory of events occurring immediately after injury.
- ☐ Total number of concussions that resulted in difficulty with memory of events occurring immediately before injury.
- ☐ Total games that were missed as a result of all concussions combined.

Please List your five most recent concussions:

Month	**/**	**Year**
_____	**/**	_____
_____	**/**	_____
_____	**/**	_____
_____	**/**	_____
_____	**/**	_____

Indicate whether you have experienced 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 History of brain surgery
☐ Yes ☐ No History of meningitis
☐ Yes ☐ No Treatment for substance/ alcohol abuse
☐ Yes ☐ No Treatment for psychiatric condition (depression, anxiety etc.)

Have you ever been diagnosed with any of the following conditions?

ADD/ADHD
☐ **Yes** ☐ **No**

Dyslexia
☐ **Yes** ☐ **No**

Autism
☐ **Yes** ☐ **No**

II. Current symptoms and conditions

Date of last concussion: ____-____-_____ (month- day- year)

Total hours of sleep last night: _____hours

Current medications:_____

Please check the box below that indicates how you normally feel:

No symptoms"0"-------Moderate "3"---------Severe"6"

Headache	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Nausea	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Vomiting	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Balance problems	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Dizziness	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Fatigue	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Trouble falling to sleep	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Sleeping too much	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Sleeping too little	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Drowsiness	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Sensitivity to light	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Sensitivity noise	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Irritability	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Sadness	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Feeling nervous	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Feeling emotional	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Numbness or tingling	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Feeling too slow	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Mentally foggy	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Difficulty concentrating	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Memory problems	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6
Visual problems	☐	0	☐	1	☐	2	☐	3	☐	4	☐	5	☐ 6