Children's Hospital LOS ANGELES SPORTS MEDICINE PROGRAM

Concussion Patient Self-Assessment: FOLLOW-UP

Name:_____ Date:_____

Age: _____ Date of Birth: _____ Gender: Male/Female PMD:_____

Details of Current Injury

Date of Injury:_____ Sport: _____

How did the injury occur?: Head-head contact Head-body part contact Head-object contact

How do you feel since your previous visit: Better Worse Unchanged

Please describe current symptoms and concerns:

_____

_____

_____

_____

Do symptoms worsen with MENTAL activity? Yes No

If yes, what activities increase symptoms? _____

Do symptoms worsen with PHYSICAL activity? Yes No

If yes, what activities increase symptoms? _____

Since the previous visit has the patient engaged in:		
Strenuous exercise?	Yes/No	If yes, what activity? If yes, did symptoms worsen/recur? Yes/No
School attendance?	Yes/No	If yes, what date did patient return to school?: _____ If yes, is patient attending: Full days? Partial days? Describe current attendance and related issues:
Homework?	Yes/No	If yes, is patient completing regular coursework or modified work load? Describe current workload? If yes, do symptoms worsen/recur during activity? Yes/No
Video games?	Yes/No	If yes, do symptoms worsen/recur during use? Yes/No
Computer use (>5min/day)?	Yes/No	If yes, do symptoms worsen/recur during use? Yes/No
Smart phone use (>5min/day)?	Yes/No	If yes, do symptoms worsen/recur during use? Yes/No
Tablet/iPad use (>5min/day)?	Yes/No	If yes, do symptoms worsen/recur during use? Yes/No

Name: _____

CURRENT Symptoms (Symptoms you feel since previous visit) Circle appropriate severity/timing/change since previous.			
Symptom	Severity	Timing	Since previous visit, symptoms are:
Memory loss: For events that occurred immediately BEFORE or AFTER injury	None/Mild/Moderate/Severe	Constant/Intermittent	
Disorientation/Confusion	None/Mild/Moderate/Severe	Constant/Intermittent	
Headache	None/Mild/Moderate/Severe	Constant/Intermittent	Throbbing/pressure/dull Worse AM / PM What makes it worse?
"Pressure in head"	None/Mild/Moderate/Severe	Constant/Intermittent	
Neck Pain	None/Mild/Moderate/Severe	Constant/Intermittent	
Dizziness	None/Mild/Moderate/Severe	Constant/Intermittent	
Nausea	None/Mild/Moderate/Severe	Constant/Intermittent	
Vomiting	Yes/No	How many episodes?_	
Balance problems	None/Mild/Moderate/Severe	Constant/Intermittent	
Seizure activity	Yes/No	How many episodes?_	
Numbness/tingling	None/Mild/Moderate/Severe	Constant/Intermittent	
Change in vision (Difficulty seeing, seeing double, seeing spots or any other changes)	None/Mild/Moderate/Severe	Constant/Intermittent	
Sensitivity to light	None/Mild/Moderate/Severe	Constant/Intermittent	
Hearing changes (Ringing in the ears, difficulty hearing or any other changes)	None/Mild/Moderate/Severe	Constant/Intermittent	
Sensitivity to sound	None/Mild/Moderate/Severe	Constant/Intermittent	
"Don't feel right"	None/Mild/Moderate/Severe	Constant/Intermittent	
Feeling slowed down	None/Mild/Moderate/Severe	Constant/Intermittent	
Feeling "in a fog"/"dinged"	None/Mild/Moderate/Severe	Constant/Intermittent	
Difficulty remembering	None/Mild/Moderate/Severe	Constant/Intermittent	
Difficulty Concentrating	None/Mild/Moderate/Severe	Constant/Intermittent	
Low Energy/Fatigue	None/Mild/Moderate/Severe	Constant/Intermittent	
Sleep changes:____hrs/night	None/Mild/Moderate/Severe	Sleeping MORE or LESS than usual?	Taking naps?
More emotional	None/Mild/Moderate/Severe	Constant/Intermittent	
Easily annoyed or moody	None/Mild/Moderate/Severe	Constant/Intermittent	
Sadness	None/Mild/Moderate/Severe	Constant/Intermittent	
Nervousness/anxiety	None/Mild/Moderate/Severe	Constant/Intermittent	
Other:			