Think Head First
Coalville Health Center
435 336-4403

Baseline Worksheet

Demographic and Background Information

General Information

Name_________________________________ **DOB**_____________

SS# ________--_______--________ **Height**______ **Weight**__________

School/ Club / Organization__________________________________

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

Language

Native Language____________________________

Education

Years of Education Completed (e.g., high school senior is 11 years) ________years

Check any of the following that apply:

- ☐ Received speech therapy
- ☐ Attended special education classes
- ☐ Repeated one or more years of school
- ☐ Diagnosed attention deficit disorder or hyperactivity
- ☐ Diagnosed learning disability

Sports

Current Sport:____

position/ event/ class____________________________________
(if team sport)

level of participation__________________________________
(e.g.: high school, semi-professional, collegiate, other 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 number of games that were missed as a result of concussions

Please List your five most recent concussions: ______________________________
(use approximate dates if needed) ______________________________

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.)

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 the degree to which you are CURRENTLY experiencing the following symptoms:

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

Symptom							
Headache	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Nausea	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Vomiting	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

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

Symptom							
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
Excessive sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Loss of sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Drowsiness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Light sensitivity	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Noise sensitivity	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Irritability	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Sadness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Nervousness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
More emotional	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Numbness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Feeling "slow"	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Feeling "foggy"	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Difficulty concentrating	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Difficulty remembering	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Visual problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

****Please leave all paperwork in clinical testing room when completed**
**** All remaining portions of the test will be performed in a clinical room**