Concussion Initial PCS Encounter

Patient Name:	**Today's Date:**
Date of Injury:	
Address:	
City:	**St:** **Zip:**
Email:	**Cell Phone:**

HISTORY

Mechanism of Injury:

Direct Head Trauma:	No ☐ Yes ☐
Loss of Consciousness:	No ☐ Yes ☐
Amnesia:	
Retrograde:	No ☐ Yes ☐ _____ (Time)
Anterograde:	No ☐ Yes ☐ _____ (Time)
Current Symptoms:	
Exertion:	
Physical Activity: Symptoms Worsen	No ☐ Yes ☐
Cognitive Activity: Symptoms Worsen	No ☐ Yes ☐
Other Symptoms Noted:	
Report / Evidence of Slurred Speech	No ☐ Yes ☐
Severe / Worsening HA	No ☐ Yes ☐
Can't Recognize People	No ☐ Yes ☐
Decreasing Consciousness	No ☐ Yes ☐
Seizures	No ☐ Yes ☐
Increasing Confusion / Irritability	No ☐ Yes ☐
Increasing Drowsiness	No ☐ Yes ☐
Signs of Skull Fracture	No ☐ Yes ☐
Vomiting x 2 Since Injury	No ☐ Yes ☐
Unusual Behavior Change	No ☐ Yes ☐
GCS < 15	No ☐ Yes ☐
Concussion History:	No ☐ Yes ☐ (Dates)
Medications:	
Anticoagulants:	No ☐ Yes ☐
Antiplatelets:	No ☐ Yes ☐
Complicating Factors:	
Behavioral Disorder	No ☐ Yes ☐
History of Headaches	No ☐ Yes ☐
History of Anxiety	No ☐ Yes ☐
History of Depression	No ☐ Yes ☐
History of Sleep Disorder	No ☐ Yes ☐
History of Mental DX	No ☐ Yes ☐