SWEDISH MEDICAL GROUP

ImPACT Baseline Demographic and Background Information

Date of Birth: _____ month _____ date _____year

First Name: _____ Last Name: _____

Height: _____ft _____in Weight: _____

Gender: _____ male _____ female

Handedness: _____ right _____ left _____ ambidextrous (both right and left)

Parent e-mail: _____

Native Country (default: United States): _____

Native Language: _____

Second Language: _____ (only if fluent in speaking and writing)

Ethnicity:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other pacific islander
- ☐ White

Years of education completed excluding kindergarten: _____(e.g., current high school senior is 11 years)

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

While in school, what type of student were / are you?
_____ Below Average _____Average _____Above Average

Current Sport: (pick one) _____

Current position / event / class: _____
(e.g., quarterback, forward, 1st base, etc.)

Current level of participation: _____(e.g., junior high, high school)

Years of experience at this level: _____ (0 - 4) (e.g., number of years in high school, high school senior = 3)

Concussion History

_____ Number of times diagnosed with a concussion
_____ Total number of concussions that resulted in loss of consciousness
_____ Total number of concussions that resulted in confusion
_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately after injury
_____ Total number of concussions that resulted in difficulty with memory for events that occurred immediately before injury
_____ Total number a games that were missed as a direct result of all concussions combined

Please list your 5 most recent concussions:_____ month _____ year
_____ month _____ year
_____ month _____ year
_____ month _____ year
_____ month _____ year

Indicate if you have had any of 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 Treatment for brain surgery
_____ yes _____ no Treatment for meningitis
_____ yes _____ no Treatment for substance abuse / alcohol abuse
_____ yes _____ no Treatment for psychiatric condition (depression, anxiety)

Have you been diagnosed with any of the following?

_____ yes _____ no ADD/ ADHD
_____ yes _____ no Dyslexia
_____ yes _____ no Autism

Have you participated in any strenuous exercise and/or exertion in the last 3 hrs?

_____ yes _____ no

Date of your last concussion: _____ month _____ date _____ year

Number of hours slept last night: _____ (approximate if uncertain)

Please list any **PRESCRIPTION** medication (s) you are currently taking:

_____
_____
_____