

Dr. Danielle DeGiorgio, DO

Confidential Medical History
Concussion Intake Form

Name: _____ Date of Birth: _____ Date of Injury: _____

Age: _____ Height: _____ Weight: _____ Current Sport: _____

Occupation/School: _____ Who referred you? _____

How did the injury occur? _____

Did you lose consciousness? Yes No

Do you remember everything before the injury? Yes No After the injury? Yes No

Were you seen at the ER? Yes No If yes, any imaging done? MRI CT Xray None

Have you ever had a prior concussion? Yes No If yes, how many? _____ Date of most recent? _____

Do you have ADHD or any learning disability? Yes No _____

Personal or family history of anxiety/depression or other psychiatric disorder? Yes No _____

Personal or family history of headaches? Yes No _____

Do you have any other medical conditions? _____

Underline your initial symptoms. **Circle** your current symptoms: NONE

- | | | |
|----------------------|------------------------|------------------------|
| Headaches | Vomiting | Feeling more emotional |
| Nausea | Dizziness | Nervousness |
| Fatigue | Feeling mentally foggy | Drowsiness |
| Visual problems | Problems concentrating | Sleeping more |
| Balance problems | Problems remembering | Sleeping less |
| Sensitivity to light | Feeling slowed down | Trouble falling asleep |
| Sensitivity to noise | Irritability | |
| Numbness/Tingling | Sadness | |

Do any of the above symptoms worsen with physical or mental exertion? Yes No

Are you currently taking any medications for the above symptoms? If yes, please list: _____

Patient Name: _____ Date of Birth: _____

Medical History

Please list your medical problems, e.g., high blood pressure, diabetes, high cholesterol, depression, and any condition for which you are prescribed a medication, etc.: _____

Females only – Do you think you might be pregnant at this time? Yes No

Surgical History

Have you ever had surgery? Yes No If yes, please describe: _____

Family History

Please list the medical problems of your immediate family, e.g., arthritis, bleeding problems, cancer, diabetes, heart disease, high blood pressure, neurologic problem, osteoporosis, etc.:

Mother: _____

Father: _____

Sibling(s): _____ Not applicable

Social History

Marital status: Single Married Partner Divorced Widowed

Do you have children? Yes No If yes, how many? _____

Are you currently employed? Yes No Retired

If yes, please list your employer and occupation: _____

Do you use tobacco? Yes No If yes, how much and how often? _____

Do you use alcohol? Yes No If yes, how much and how often? _____

Before your current injury/symptoms, please describe your typical physical activity: _____

Are there any upcoming events that may affect your treatment plan, e.g., race, competition, travel?

Medications

Please list your current medications, both prescription and over-the-counter: _____

Please list any supplements that you take regularly: _____

Allergies

What medications are you allergic to? _____

Are you allergic to contrast dyes? Yes No Are you allergic or sensitive to latex? Yes No

Patient Name: _____ Date of Birth: _____

Review of Systems

Check any symptom below that you are currently experiencing or have experienced in the past weeks:

- | | | | | | |
|------------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|
| Abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glasses | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headache | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Balance problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood in urine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hot flashes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blurry vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Immune system issue | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bowel incontinence | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insomnia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cellulitis (infection) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Irregular heartbeat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cold intolerance | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint stiffness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Constipation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Muscle aches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Contacts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nose bleeds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Coordination problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pain with urination | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ringling in ears | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seasonal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Double vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Easy bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Easy bruising | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sore throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eating disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Urinary incontinence | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive thirst | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight gain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fatigue | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fever/chills | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wheezing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

What goals do you have for today's visit? _____

Is there anything else that you would like your care team to know about you? _____

Would you like today's note to be sent to another physician? Yes No

****If yes, please complete a Medical Release form and provide your doctor's information.****
The Medical Release form can be found at the front desk.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____