OhioHealth

ImPact Testing Demographics Sheet

Please PRINT clearly to ensure accuracy by our test administrators

School/ Organization: _____

Date of Birth (mm/dd/yyyy) _____

Name: First: _____ Last: _____

Height (ft and in): _____ Weight (in lbs): _____

Gender: _____ Handedness (Right, Left, Both): _____

Native Country: _____ Native Language: _____

Total Years of Education (not including Kindergarten): _____

Please Check all That Apply:

_____ Received Speech Therapy _____ Attended (s) Special Education Classes

_____ Repeated a Grade _____ Diagnosed with a Learning Disability

_____ Diagnosed Attention Deficit and/or Hyperactive (ADD/ADHD)

Please Check One: While in school what type of student are/were you:

_____ Below Average _____ Average _____ Above Average

Sport are you currently playing_____ Position you Play _____

Please Check the level that you are currently competing in:

_____ Profession _____ Semi-Professional _____ Collegiate _____ High School

_____ Junior High School/Middle School _____ Other

How many years you have played at this level? (do not count this current year): _____

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For the following questions about your injury history, please place your answers on the lines provided: If you have never had a concussion mark zero and move to next slide on screen

_____ The number of times you have been diagnosed with a concussion

_____ The total number of concussions that resulted in the loss of consciousness

_____ The total number of concussions that resulted in confusion

_____ The total number of concussions that resulted in difficulty with memory for events occurring immediately after the injury

_____ The total number of concussions that resulted in difficulty with memory for events occurring immediately before the injury

_____ Total number of games missed as a direct result of all concussions combined

Please list the five most recent concussions you have sustained by date (you can approximate): if zero, you can skip this question

1. _____ 2. _____ 3._____ 4. _____ 5. _____

For the next set of questions please circle yes or no for each of the statements as they relate to you:

YES or NO Treatment received for headaches by a physician

YES or NO Treatment for migraine headaches by a physician

YES or NO Treatment for epilepsy/seizures

YES or NO Treatment for brain surgery

YES or NO Treatment for meningitis

YES or NO Treatment for substances/alcohol

YES or NO Treatment for psychiatric conditions such as depression or anxiety

YES or NO Have you ever been diagnosed with ADD/ADHD

YES or NO Have you ever been diagnosed with Dyslexia

YES or NO Have you ever been diagnosed with Autism

YES or NO Have you participated in strenuous exercise and/or exertion in the last 3 hours

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Date of last concussion _____ if you have not had one, leave blank

Hours of Sleep last night _____

Current Medications

_____

_____

The next section is about symptoms that you are feeling currently. The score for each is a range from 1-6 with 1 being very little and 6 being extreme. If you are not currently experiencing the symptom, please mark: Not experiencing

Headache: ____Not Exp or 1-6: _____

Vomiting: ____Not Exp or 1-6: _____

Nausea: ____Not Exp or 1-6: _____

Balance Problems: ____Not Exp or 1-6: _____

Sleeping too little: ____Not Exp or 1-6: _____

Drowsiness: ____Not Experiencing or 1-6: _____

Sensitivity to light: ____Not Exp or 1-6: _____

Sensitivity to Noise: ____Not Exp or 1-6: _____

Dizziness: ____Not Exp or 1-6: _____

Fatigue: ____Not Exp or 1-6: _____

Trouble Falling Asleep: ____Not Exp or 1-6: _____

Too Much Sleep: ____Not Exp or 1-6: _____

Irritability: ____Not Exp or 1-6: _____

Sadness: ____Not Exp or 1-6: _____

Feeling Nervous: ____Not Exp or 1-6: _____

Feeling Emotional: ____Not Exp or 1-6: _____

Numbness or Tingling: ____Not Exp or 1-6: _____

Feeling too slow: ____Not Exp or 1-6: _____

Mentally Foggy: ____Not Exp or 1-6: _____

Difficulty Concentrating: ____Not Exp or 1-6: _____

Memory Problems: ____Not Exp or 1-6: _____

Visual Problems: ____Not Exp or 1-6: _____