Luminis Health

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

NEW PATIENT FORM

Patient Name: ______________________ Today's Date: __________ Date of Concussion: _________
Date of Birth: ________ Age: ____ Gender: ☐Male ☐Female School: ________________ Grade: ___
Form Completed By: ☐Patient ☐Mother ☐Father ☐Grandparent ☐ Other: ______________________
Who referred you here: ☐Trainer/Coach ☐Primary Care Physician ☐ER ☐ Other: ________________

Does patient believe he/she is completely back to normal now? ☐No ☐Yes
Do others that know the patient believe he/she is completely back to normal now? ☐All ☐Some ☐None ☐Unsure

Details of Injury

Cause of concussion: ☐Sport (specify) ________________ ☐Motor vehicle crash ☐Hit by motor vehicle
☐Fall ☐Assault ☐Other (specify) _________________________
Location of impact: ☐Head ☐Neck ☐Chest ☐Abdomen ☐Other: ____________________
Direction of Impact: ☐Front ☐Back ☐Left Side ☐Right Side ☐Unsure ☐Other: ______________
Did the patient lose memory of any events BEFORE the injury? ☐No ☐Yes If Yes, how long? ____ Minutes ____ Hours
Did the patient lose memory of any events AFTER the injury? ☐No ☐Yes If Yes, how long? ____ Minutes ____ Hours
Did the patient lose consciousness (witnessed not moving or responding)? ☐Unknown ☐No ☐Yes
If Yes, how long? ____ Seconds ____ Minutes ____ Hours
Did the patient appear dazed or stunned after the injury? ☐Unknown ☐No ☐Yes
Did the patient have a headache soon after the injury? ☐Unknown ☐No ☐Yes
Did the patient vomit after the injury? ☐Unknown ☐No ☐Yes
Has the patient seen a medical provider? ☐No ☐Yes If Yes, when? ☐Same day ☐1-2 days later ☐More than 3 days
Was a head CT or brain MRI done? ☐No ☐Yes If Yes, were any problems identified? ☐No ☐Yes
Did the patient miss any days of school or work? ☐N/A ☐No ☐Yes If Yes, how many? ____________

Symptom Checklist

Please rate the patient's symptoms for TODAY and for the FIRST FEW DAYS AFTER THE CONCUSSION.

	TODAY				**FIRST FEW DAYS AFTER CONCUSSION**			
	None	**Mild**	**Moderate**	**Severe**	**None**	**Mild**	**Moderate**	**Severe**
Headache	0	1	2	3	0	1	2	3
Nausea	0	1	2	3	0	1	2	3
Vomiting	0	1	2	3	0	1	2	3
Balance problem/dizziness	0	1	2	3	0	1	2	3
Fatigue/Drowsiness	0	1	2	3	0	1	2	3
Sleeping less than usual	0	1	2	3	0	1	2	3
Sleeping more than usual	0	1	2	3	0	1	2	3
Trouble falling asleep	0	1	2	3	0	1	2	3
Blurry or double vision	0	1	2	3	0	1	2	3
Sensitivity to light	0	1	2	3	0	1	2	3
Sensitivity to noise	0	1	2	3	0	1	2	3
Feeling "foggy"	0	1	2	3	0	1	2	3
Trouble concentrating	0	1	2	3	0	1	2	3
Trouble remembering	0	1	2	3	0	1	2	3
Feeling irritable	0	1	2	3	0	1	2	3
Feeling sad	0	1	2	3	0	1	2	3
Feeling nervous	0	1	2	3	0	1	2	3

Do any of the current symptoms worsen with physical activity? ☐No ☐Yes
Do any of the current symptoms worsen with mental activity? ☐No ☐Yes

As of today, how different does the patient feel from normal? ☐Normal ☐A little different ☐Somewhat ☐A lot
Has the patient now returned to sports or work? ☐Completely ☐Partially ☐None ☐N/A
Has the patient now returned to school? ☐Completely ☐Partially ☐None ☐N/A
Has the patient ever undergone computerized neuropsychological testing? ☐No ☐Yes ☐Unsure
Has the patient ever undergone formal neuropsychological testing? ☐Unsure ☐No ☐Yes If Yes, where? ____________

Medical History

Has the patient previously had any concussions? ☐No ☐Yes If Yes, how many? ____________
Please list the approximate dates of each concussion and how long it took for symptoms to go away after each concussion: ____

Please list any medications the patient is currently taking: ____

Before the concussion, had the patient ever had migraine headaches or frequent or severe headaches? ☐No ☐Yes
Has anyone in the family ever been diagnosed with migraine headaches or any other headache disorder? ☐No ☐Yes
If Yes, who? ____________________
Has the patient ever been diagnosed with any of the following?

☐No ☐Yes Attention-Deficit/Hyperactivity Disorder
☐No ☐Yes Learning Disability
☐No ☐Yes Anxiety
☐No ☐Yes Depression
☐No ☐Yes Bipolar Disorder
☐No ☐Yes Other Psychiatric Disorder: ____________________
☐No ☐Yes Sleep Problem
☐No ☐Yes Seizure Disorder
☐No ☐Yes Other Medical Problem: ____________________