Luminis Health℠

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Annapolis, Md. 21401
LuminisHealth.org

RETURN 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: _____

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

Symptom Checklist

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

	TODAY			
	None	**Mild**	**Moderate**	**Severe**
Headache	0	1	2	3
Nausea	0	1	2	3
Vomiting	0	1	2	3
Balance problem/dizziness	0	1	2	3
Fatigue/Drowsiness	0	1	2	3
Sleeping less than usual	0	1	2	3
Sleeping more than usual	0	1	2	3
Trouble falling asleep	0	1	2	3
Blurry or double vision	0	1	2	3
Sensitivity to light	0	1	2	3
Sensitivity to noise	0	1	2	3
Feeling "foggy"	0	1	2	3
Trouble concentrating	0	1	2	3
Trouble remembering	0	1	2	3
Feeling irritable	0	1	2	3
Feeling sad	0	1	2	3
Feeling nervous	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
If back to normal, when were the last symptoms? _____
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

Any other details: _____